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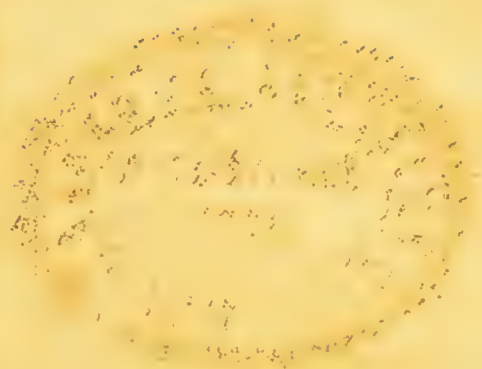
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KING'S COLLEGE LONDON





THE  
PRINCIPLES  
OF  
MIDWIFERY;  
INCLUDING THE  
DISEASES



SECOND EDITION, MUCH ENLARGED.

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By JOHN BURNS,

LECTURER ON MIDWIFERY, AND MEMBER OF THE FACULTY OF PHYSICIANS  
AND SURGEONS, GLASGOW.

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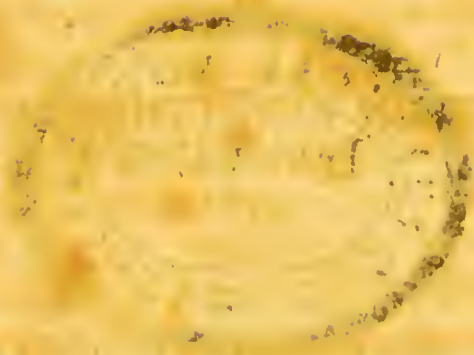
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## PREFACE.

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IN preparing this work, I have endeavoured to proceed as much as possible upon the method of induction. I have collected with care the different cases which have been made public, as well as my own private observations. To these I have added the opinions and advices given by others, in so far as they seemed to be founded on facts, and supported by experience. From the whole I have deduced, in the different parts of my subject, both the symptoms and the practice.

The anatomical descriptions, I have given from dissections and preparations before me whilst writing.

I intended to have added to the text, copious references to the opinions and cases contained in systems, or scattered through other publications. This would have rendered the present book, in some manner, an index to those already published, and been of considerable service to practitioners, who wished to consult them upon any particular point. But in spite of all my endeavours, this work has extended to a length, which rendered it necessary to strike out many references, and shorten the account of cases, to prevent it from swelling to a size which would have rendered it less generally useful.



Whilst I thus state the plan on which I have proceeded, I acknowledge myself deeply sensible, that its execution does not bear any proportion to the importance of the subject. Should this work fall only into the hands of those, competent to judge on their profession, it would, if faulty or deficient, do little harm : But should it ever be circulated more extensively, it must, like other systems and elements, have an influence on the opinions and future practice of the student of midwifery ; and will prove useful or injurious to society, according to the correctness of the principles it contains. When I consider how important the diseases of women and children are, and how much depends on the prudent management of parturition, I feel the high responsibility which falls on those who presume to give lessons in midwifery. I do, however, sincerely trust, that the precepts I have inculcated will, in general, be found agreeable to the experience and practice of our best teachers ; and, on a review of the whole, I cannot say that I have either wasted the reader's time in idle theory, or misled his opinion by mere speculation.

In preparing a second edition for the press, I have carefully revised the whole work, and have made many additions, which I hope will prove useful.

Notwithstanding considerable attention, some typographical errors exist in the work, but I hope the context will render them sufficiently evident. In the additions, in one or two places, the punctuation is incorrect ; but the reader can easily discern the mistakes, and therefore I do not put them into a list of errata.

In

In page 111, line 8, for *peinguedinem* read *pinguedinem*.

In 469, last line, for *wash* read *washing*.

Two additions have not been inserted, which the reader is requested, to make a reference, to in the work with his pen, namely, in page 360, line 14, after the word "tried," add,

"I have, however, derived more advantage, in these cases, from purgatives, than any other medicine. In every case which I have attended, they have brought away dark or offensive stools, with great relief to the symptom. Indeed I am much inclined to consider an incorrect state of the bowels as one of the most powerful predisposing causes of puerperal convulsions; and sometimes, particularly before labour commences, as the chief exciting cause."

Page 519, line 1st, after "roseola," add,

"This disease appears to be, in a certain form, infectious. For, in particular seasons, I have observed it to be unusually prevalent, and to affect all the children of a family. In such cases, the eruption has lasted from two to four days, and has been attended with very little fever."

Glasgow,     }  
July, 1811.    }

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THE  
PRINCIPLES  
OF  
*M I D W I F E R Y.*

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BOOK I.

OF THE STRUCTURE, FUNCTIONS, AND DISEASES OF THE PELVIS  
AND UTERINE SYSTEM, IN THE UNIMPREGNATED  
STATE, AND DURING GESTATION.

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CHAP. I.

*Of the Bones of the Pelvis.*

SECTION FIRST.

THE practical precepts, and rules in Midwifery, are easily understood, and readily acquired. They arise evidently from the structure and actions of the parts concerned in parturition; and whoever is well acquainted with this structure and these actions, may, from such knowledge, deduce all the valuable and important directions which constitute the Practice of Midwifery.

One of the first, and not the least important, of those parts concerned in parturition, is the pelvis, which must be examined, not only on account of its connection with the uterus and vagina, but also of its own immediate relation to the delivery of the child, and the obstacles which, in many instances, it opposes to its passage.

The pelvis consists, in the full grown female, of three large bones, two of which are very irregular, having no near resemblance to any other object; on which account they have been called the ossa innominata. These form the sides and front of the basin or pelvis. The back part consists of a triangular bone, called the os sacrum, to the inferior extremity or apex of which, is attached, by a moveable articulation, a small bone, which, from its supposed resemblance to the beak of a cuckoo, has been named the os coccygis.

The os innominatum, at first, consists of three separate pieces: the upper portion is called the ilium, or haunch bone; the under portion the ischium, or seat bone; and the anterior division, which is the smallest of the three, is called the os pubis, or share bone. These all join together in the acetabulum, or socket, formed for receiving the os femoris, and are connected by a very firm gristle or cartilage. This, before the age of puberty, is converted into bone, so that the three different pieces are consolidated into one, though the names given to the bones originally are still applied to the different parts of the united os innominatum.

The sacrum also, which seems to consist only of one curved triangular bone, is really made up of several pieces, which, in the child, are nearly as distinct as the vertebræ, to which, indeed, they bear such a resemblance, that they have been considered as a continuation of them; but from their imperfect structure, and subsequent union, they have been called the false vertebræ.

The bones of the pelvis are firmly joined together, by means of ligaments and intermediate cartilages, and form a very irregular canal, the different parts of which must be briefly mentioned.

#### SECTION SECOND.

When we look at the pelvis, we observe, that the ossa innominata naturally divide themselves into two parts, the uppermost of which is thin and expanded, irregularly convex on its dorsum or outer surface, hollow on the inside, which is called the costa, and bounded by a broad margin, extending in a se-

micircular direction from before backwards, which is called the crest of the ilium. The under part of the os innominatum is very irregular, and forms, with the sacrum, the cavity of the pelvis. The upper expanded part has little influence on labour, and serves, principally, for affording attachment to muscles. In the under part, we have several points to attend to.

1st. The upper and under parts form an angle with each other, marked by a smooth line, which is a continuation of the margin of the pubis, or anterior part of the bone. It extends from the symphysis pubis, all the way to the junction of the os innominatum with the sacrum, and is called the *linea iliopectinea*. It is quite smooth and obtuse at the sides, where the two portions form an angle; but at the anterior part, where the upper portion is wanting, it is sharp, and sometimes is elevated into a thin spine like the blade of a knife.

2d. The upper portion is discontinued exactly about the middle of this line, or just over the acetabulum; and at the termination, there is from this portion an obtuse projection overhanging the acetabulum, which is called the inferior spinous process of the ilium, to distinguish it from a similar projection about half an inch higher, called the superior spine.

3d. The under part of the bone is of the greatest importance, and in it we recognise the following circumstances. Its middle is large, and forms on the outside a deep cup or acetabulum, for the reception of the head of the thigh bone. On the inside, and just behind this cup, it forms a smooth polished plate of bone within the cavity of the pelvis, which is placed obliquely with regard to the pubis, and has a gentle slope forward. The vertex of the child's head, in labour, moves downwards, and somewhat forwards, on this, as on an inclined plane; it may be called the plane of the ischium, although a part of it be formed by the ilium.

4th. Standing off from the back part of this, about two inches beneath the *linea iliopectinea*, is a short projection.



called the spine of the ischium, which seems to encroach a little on the cavity of the pelvis, and is placed, with regard to the pubis, still more obliquely than the plane of the ischium. It must, consequently, tend to direct the vertex, as it descends, still more towards the pubis.

5th. Beneath this, the ischium becomes narrower, but not thinner; on the contrary, it is rather thicker, and terminates in a rough bump, called the tuberosity of the ischium.

6th. Next, we look at the anterior part of the bone, and find, that just before the plane of the ischium, there is a large hole in the os innominatum. This is somewhat oval in its shape; and at the upper part within the pelvis, there is a depression in the bone, which, if followed by the finger or a probe, leads to the face of the pelvis. The hole is called the foramen thyroideum.

7th. Before this hole the two ossa innominata join, but form with each other, on the inside, a very obtuse angle, or a kind of smooth rounded surface, on which the bladder partly rests. The junction is called the symphysis of the pubis.

8th. The two bones, where they form the symphysis, are joined with each other for about an inch and a half; then they divaricate, forming an angle, the limbs of which extend all the way to the tuberosity of the ischium. This separation or divarication is called the arch of the pubis, which is principally constructed of the anterior boundary of the foramen thyroideum, consisting of a column or piece of bone, about half an inch broad, and one fourth of an inch thick, formed by the union of the ramus of the pubis, and that of the ischium.

9th. At the upper part of the symphysis, or a very little from it, the os innominatum has a short obtuse projection, called the crest of the pubis, into which Poupart's ligament is inserted; and from this there runs down obliquely, a ridge on the outside of the bone, which reaches all the way to the acetabulum, and overhangs the foramen thyroideum.

10th. When we return to the back part of the os innominatum, we find, that just after it has formed the plane of the



ischium, it extends backwards to join the sacrum; but in doing so, it forms a very considerable notch or curve, the concavity of which looks downwards. When the sacrum is joined to the bone, this notch is much more distinct. It is called the sacrosciatic notch or arch: for one side is formed by the ischium, and is about two inches long; the other is formed chiefly by the sacrum, and is about half an inch longer. In the recent subject, strong ligaments are extended at the under part, from the one bone to the other; so that this notch is converted into a regular oval hole.

11th. Lastly, this notch being formed, the bone expands backwards, forming a very irregular surface for the articulation with the sacrum; and the bones being joined, we find that the os innominatum forms a strong, thick, projecting ridge, extending farther back than the spinous processes of the sacrum. This ridge is about two inches and three quarters long, and is a continuation of the crest of the ilium, but is turned downwards; whereas were the crest continued in its former course, it would meet with the one from the opposite side, behind the top of the sacrum, forming thus a neat semicircle; but this ridge, if prolonged on both sides, would form an acute angle, the point of junction being opposite the bottom of the sacrum. From this ridge strong ligaments pass to the sacrum, to join the two bones.

#### SECTION THIRD.

The sacrum forms the back part of the pelvis. It is a triangular bone, and gently curved; so that, whilst a line drawn from the one extremity to the other, measures, if it subtend the arch, about four inches; it will, if carried along the surface of the bone, measure full half an inch more. The distance betwixt the first or straight line, and the middle of the sacrum is about one inch. The breadth of the base of the sacrum, considered as an angular body, is full four inches: the centre of this base is shaped like the surface of the body of one of the lumbar vertebræ, with the last of which it joins, forming, however, an angle with it, called the great angle, or promontory of the sacrum. From this the bone is

gently curved outward on each side, toward the sacro-iliac junction, contributing to the formation of the brim of the pelvis.

The upper half of the side of the bone is broad and irregular for articulation with the os innominatum. The anterior surface of the bone is smooth and concave; but often we observe transverse ridges, marking the original separation of the bones of the sacrum. Four pair of holes are found disposed in two longitudinal rows on the face of the sacrum, communicating with the canal which receives the continuation of the spinal marrow; through these the sacral nerves issue. These holes slope a little outward, and betwixt the two rows is the attachment of the rectum. The posterior surface of the bone is very irregular; and, we observe, 1st, The canal extending down the bone, for receiving the continuation of the spinal marrow. 2d. At the upper part of this are two strong oblique processes, which join with those of the last lumbar vertebra. 3d. On a central line down the back of the canal, there is an irregular ridge analogous to the spines of the vertebræ. 4. The rest of the surface is very irregular and rough; and we observe, corresponding to the holes for transmitting the sacral nerves on the exterior surface, the same number of foramina on this posterior surface, but, in the recent subject, they are covered with membrane, leaving only a small opening for the exit of nervous twigs.

The coccyx is an appendage to the sacrum, and as it is inclined forwards from that bone, the point of junction has been called the little angle of the sacrum. It is, at first, altogether cartilaginous, and cylindrical in its shape, but it gradually ossifies and becomes flatter, especially at the upper part, which has been called its shoulder. In men it is generally anchylosed with the sacrum, or at least moves with difficulty, but it almost always separates by maceration. In women it remains mobile, and, during labour, is pressed back so as to enlarge the outlet of the pelvis. By falls or blows it may be luxated; and if this be not discovered, and the bone replaced, suppuration takes place about the rectum, and the bone is discharged.

## CHAP. II.

*Of the Articulation of the Bones of the Pelvis, and their occasional separation.*

## SECTION FIRST.

THE bones of the pelvis are connected to each other, by intermediate cartilages, and by very strong ligaments. The ossa innominata are united to each other at the pubis, in a very strong and peculiar manner. It was supposed that they were joined together by one intermediate cartilage; but Dr Hunter \* was, from his observation, led to conclude, that each bone was first of all covered at its extremity with cartilage, and then betwixt the two was interposed a medium, like the intervertebral substance, which united them: This substance consists of fibres disposed in a transverse direction.

M. Tenon † has lately published an account of this articulation; and is of opinion, that sometimes the one mode and sometimes the other obtains. I am inclined to think, that, Dr Hunter's description is applicable to the most natural state of the part; but we often in females find that the intermediate fibrous substance, especially at the posterior part, is absorbed, and its place supplied with a more fluid substance; or, on the contrary, ankylosis may sometimes take place; a circumstance which Dr Hunter says he never saw, but which I have met with. Besides this mode of connection, there is also in addition a very strong capsule to the articulation, the symphysis being covered on every side with ligamentous fibres, which contribute greatly to the strength of the parts.

\* Vide Med. Obs. and Inq. Vol. II. p. 333.

† Vide Mém. de l'Institut des Sciences, Tome VI. p. 178.



## SECTION SECOND.

The ossa innominata are joined to the sacrum by means of a thin layer of cartilaginous substance, which covers each bone; that belonging to the sacrum is the thickest: both are rough, and betwixt them is found a soft yellowish substance in small quantity. The connection of the two bones, therefore, so far as it depends on this medium, cannot be very strong; but it is exceedingly strengthened by ligamentous fibres, which serve as a capsule; and behind, several strong bands pass from the ridge of the ilium to the back of the sacrum; sometimes the bones are united by ankylosis. At the lower part, additional strength is obtained by two large and strong ligaments, which pass from the ischium to the sacrum; and therefore are called the sacrosciatic ligaments. The innermost of these arises from the spine of the ischium, is very strong, but at first not above a quarter of an inch broad; it gradually expands, however, becoming at its insertion about an inch and a quarter in breadth. It passes on to the sacrum, and is implanted into the lower part of the side of that bone, and the upper part of the coccyx. It converts the sacrosciatic notch into a regular oval hole, the inferior end of which, owing to the neat expansion of the ligament, is as round and exact as the upper. As it makes a similar expansion downwards, there is a kind of semilunar notch formed betwixt it and the coccyx. The outer ligament may be said to arise from the side of the sacrum, and, like the other, is broad at that part. It runs for some time in contact with the inner ligament, and parallel to it; but afterwards it separates, passing down to be inserted in the tuber ischii; and, when the ligaments separate, their surfaces are no longer parallel to each other. There is, in consequence of this separation, a small triangular opening formed betwixt the ligaments; or rather there is an aperture like a bow, the string being formed by the under ligament, and the arch partly by the spine of the ischium, and partly by the upper ligament.



## SECTION THIRD.

The pelvis is joined to the trunk above, by means of the last lumbar vertebra; to the extremities below, by the insertion of the thigh bones into the acetabula; and it is so placed, that when the body is erect, the upper part of the sacrum and the acetabula are nearly in the same line. The brim of the pelvis, then, is neither horizontal nor perpendicular to the horizon, but oblique, being placed at an angle of 35 or 40 degrees. Were the ligaments of the pelvis loosened, there would, from this position, be a tendency in the sacrum to fall directly towards the pubis, the ossa innominata receding on each side. But the structure of the part adds greatly to the power of the ligaments; for it is to be observed, that in standing, and in various exertions of the body, the limbs re-act on the pelvis; and the heads of the thigh bones pressing on the two acetabula, force the ossa innominata more closely on each other at the symphysis, and more firmly on the sacrum behind. It is not possible, indeed, to separate the bones of the pelvis, unless the connecting ligaments be diseased, or external violence be applied, so as to act partially or unequally on the pelvis.

## SECTION FOURTH.

By external violence, the symphysis has been wrenched open, as was the case with Dr Greene\*; or the sacro-iliac junction may be separated, as in the case of the young peasant, related by M. Louis.†

By some morbid affection of the symphysis, it may yield and become loosened during pregnancy, or may be separated during labour. Some have been inclined to consider this as an uniform operation of nature, intended to facilitate the birth of the child. Others, who cannot go this length, have nevertheless conjectured, that the ligaments do become some-

\* Phil. Trans. No. 184.

† Vide Mem. de l'Acad. de Chir. Tome IV. p. 63.

what slacker; and have grounded this opinion on the supposed fact of the pelvis of quadrupeds undergoing this relaxation. But the truth is, that this separation is not an advantage, but a serious evil; and in cases of deformed pelvis, where we would naturally look for its operation, did it really exist, we do not observe it to take place.

When a person stands, pressure is made upon the symphysis, and therefore, if it be tender, pain will then be felt. When a person walks, pressure is made on the two acetabula alternately, and the ossa innominata are acted on by the strong muscles which pass from them to the thighs, so that there is a tendency to make the one os pubis rise above the other; but this, in a sound state of the parts, is sufficiently resisted by the ligaments. In a diseased state, however, or in a case of separation of the bones, there is not the same obstacle to this motion: and hence, walking must give great pain, or be altogether impossible: even attempts to raise the one thigh above the other, in bed, must give more or less pain, according to the sensibility or laxity of the symphysis. Standing has also an effect on the symphysis, as I have mentioned; but sometimes the person can, by fixing one os innominatum, with all the muscles connected with it, and throwing the chief weight of the body to that side, stand, for a short time, easier on one leg than on both. This is the case when one os innominatum has been more acted on than the other, at the sacro-iliac junction. The person can stand easiest on the soundest side.

From these observations, we may learn the mischievous consequences of a separation of the bones, and also the circumstances which will lead us to suspect that it has happened. If the bones be fully disjoined, then, by placing the finger on the inside of the symphysis, and the thumb on the outside, we can readily perceive a jarring, or motion, on raising the thigh.

It is well known to every practitioner, that owing to the distension of the muscles during pregnancy, very considerable pain is sometimes felt at the insertion of the rectus muscle into the pubis; and it is also known, that sometimes,

in consequence of pregnancy, the parts about the pelvis, and especially the bladder and urethra, and even the whole vulva, may become very irritable. This tender state may be communicated to the symphysis; or some irritation, less in degree than that I have mentioned, may exist, which, in particular cases, seems to extend to the articulation, producing either an increased effusion of interstitial fluid in the intermediate cartilage, and thus loosening the firm adhesion of the bones, or a tenderness and sensibility of the part, rendering motion painful. In either case, exertion may produce a separation: and certainly, in some instances, has done so. The separation is always attended with inconvenience, and often with danger, especially when it occurs during parturition; for abscess may take place, and the patient sink under hectic fever; or inflammation may be communicated to the peritoneum, and the patient die in great pain.

When the accident happens during gestation, it sometimes takes place gradually, in consequence of an increasing relaxation of the articulation, from slow but continued irritation. In the other instances, it happens suddenly after some exertion. It may occur so early as the second, or so late as the ninth month, and is discovered by the symptoms mentioned above; such as pain at the pubis, strangury, and the effects of motion. In some instances, considerable fever may take place, but, in general, the symptoms are not dangerous, and I do not know any case which has terminated fatally before delivery. A state of strict rest, the application of a broad firm bandage round the pelvis, to keep the bones steady, and the use of the lancet and antiphlogistic regimen, if there be fever or much pain, are the chief points of practice. Nor must it be forgotten, for a moment, that although, by these means, the symptoms are removed, the patient is liable, during the remaining term of gestation, or at the time of delivery, to a renewal of the relaxation or separation, from causes which, in other circumstances, would have had no effect. So far as I have been able to learn, a woman who has had this separation in one pregnancy, is not,



in general, peculiarly liable to a return of it in a subsequent pregnancy, though there may be particular exceptions to this observation.<sup>1</sup>

When it happens during parturition, it sometimes takes place in a pelvis apparently previously sound ; but in most instances, we have, during some period of gestation, symptoms of disease about the symphysis ; and so far from making labour easier, the woman often suffers more, when the symphysis is previously relaxed. The primary and immediate effects are the same as when the accident happens during pregnancy ; but the subsequent symptoms are frequently much more severe and dangerous, the tendency to inflammation being strong. The pain may be either trifling or excruciating at the moment, according to the sensibility of the parts. But, even in the mildest case, great circumspection is required, violent inflammation having come on so late as a fortnight after the accident. The means used in the former case are to be rigidly employed, and the woman should keep her thighs together, and lie chiefly on her back. If the separation have been slight, re-union may take place in a few weeks, sometimes in a month<sup>2</sup> ; but if a great injury have been sustained, it may be many months, perhaps years, before recovery be completed ; and, in such cases, it is probable, that at last, an ankylosis is sometimes formed.

Either owing to the violence of the accident, or the peculiar state of the parts, it sometimes happens, that inflammation takes place to a very considerable degree in the symphysis ; but it is to be remarked, that the symptoms are by no means uniformly proportioned in their severity to the degree of the separation. Inflammation is known by the accession of fever, with acute pain about the lower part of the belly, greatly increased by motion, succeeding to the primary effects ; or, sometimes, from the first, the pain is very great, and not unfrequently it is accompanied by sympathetic derangement of the stomach and bowels, such as vomiting, nausea, looseness, &c. Presently matter forms, and a well marked hectic-state takes place. The patient is to be treated, at first, by the usual remedies for abating inflammation, such



as general and local evacuation of blood, fomentations and laxatives. When matter is formed, we must carefully examine where it is most exposed, and let it out by a small puncture.<sup>3</sup>

The inflammation may be communicated to the peritonæum, producing violent pain in the lower belly, tumefaction and fever, and almost uniformly proves fatal; though frequently the patient lives until abscess takes place in the cellular substance within the pelvis. If any thing can save the patient, it must be the prompt use of blood-letting and blisters.

In almost every case of separation of the pubis, considerable pain is felt in the loins, even although the junction at the sacrum be entire, and the ossa pubis be very little asunder. But when the separation is complete, and in any way extensive, then the articulation of the sacrum with the ossa innominata<sup>4</sup>, especially with one of them, is more injured<sup>5</sup>, and the person is lame in one or both sides, and has acute pain about the posterior ridge of the ilium,<sup>6</sup> and in the course of the psoas and glutei muscles. The mischief may also commence in the sacro-iliac articulation, and the symphysis may be little affected. The general principles of treatment are the same as in the former case. When supuration takes place about the sacro-iliac articulation, the danger is greatly increased.

In all cases of separation, when the patient has recovered so far as to be able to move, the use of the cold bath accelerates the cure; the general health is to be carefully attended to, and any urgent symptom supervening, is to be obviated by suitable remedies.

## CHAP. III.

*Of the soft Parts which line the Pelvis.*

## SECTION FIRST.

VARIOUS strong, and large muscles, pass from the spine and pelvis to the thigh bones, and act as powerful bands, strengthening, in a very great degree, the articulations of the pelvis. These it is not requisite to describe, but it will be useful, briefly to notice the soft parts which line the pelvis, and which may be acted on by the child's head during labour.

1st. When we remove the peritoneum from the cavity of the pelvis, we first of all are led to observe, that all the under portion of the os innominatum, and part of the sacrum, is covered with a layer of muscular fibres, which arises at the brim of the pelvis, and can be traced all the way down to the extremity of the rectum. This is the levator ani; it is a strong muscle, with many glossy tendinous fibres, especially at the fore part, where it lines the ossa pubis. Under the symphysis, it is pierced by the urethra and vagina; and during the passage of the child's head, those fibres which surround the vagina must be considerably distended; and this is more readily effected, as the anus is brought forwards when the perinæum is distended.

2d. Under this, on each side, we have arising from the membrane that fills up the thyroid hole, and also from the margins of the hole and the inner surface of the ischium, the obturator internus, which forms at that part a soft cushion of flesh, the fibres running backwards and downwards, and terminating in a tendon, which passes over the sacro-sciatic notch, running on it as on a pulley, in order to reach the root of the great trochanter.

3d. We find the pyriformis arising from the under part of the hollow of the sacrum, and also passing out at the

notch, to be inserted with the obturator; and in laborious parturition, the injury or pressure which these muscles sustain, is one cause of the uneasiness felt in moving the thighs.

4th. From the spine of the ischium, originates the coccygeus, which runs backward to be inserted into the side of the coccyx, in order to move and support it. This gradually becomes broader, as we recede from its origin, and is spread on the inside of the sacro-sciatic ligament. Thus the cavity of the pelvis is lined with muscular substance, whose fibres are disposed in a very regular order, and which are exhibited when the peritoneum and its cellular substance are removed.

5th. When we look at the upper part of the os innominatum, we find all the hollow of the ilium occupied with the iliacus internus, the tendon of which passes over the fore part of the pelvis, to reach the trochanter of the thigh. Part of this muscle is covered by the psoas which arises from the lumbar vertebræ, and passes down by the side of the brim of the pelvis to go out with the former muscle: though just upon the brim, it does not encroach on it, so as perceptibly to lessen the cavity. These muscles afford a soft support to the intestines and gravid uterus.

#### SECTION SECOND.

Running parallel with the inner margin of the psoas muscle, and upon the brim of the pelvis, along the posterior half of the linea iliopectinea, we have the iliac artery and vein; the artery lying, for the upper half of its course, above the vein, and for the under half on the outside of it; when filled, they, especially the vein, encroach a little on the brim. About three inches from the symphysis, they quit the brim, running rather more outward, over the part which forms the roof of the acetabulum, and pass out with the psoas muscle. The great lash of arteries and veins connected with the pelvis, and inferior extremities, is placed on the sacro-iliac junction. The iliac vessels are so situated, that they escape pressure during labour, when the



head enters the cavity of the pelvis; but the hypogastric vessels must be more or less compressed, according to the size or position of the head, but the circulation is never interrupted.

#### SECTION THIRD.

When we attend to the nerves, we find, 1st. Upon the ilium, at least four branches of cutaneous nerves, traversing the iliac, and psoas muscles, in order to pass out below Poupart's ligament. The largest of these cutaneous nerves is the outermost, which has its exit towards the spine of the ilium. These nerves, which supply chiefly the skin of the thigh, cannot suffer during labour; but sometimes may, from the position of the child, or the inclination of the uterus, sustain pressure, during gestation, and occasion numbness and anomalous sensations in the thigh. 2d. Between the two muscles, and in part covered by the outer margin of the psoas, is the anterior crural nerve, which is formed by the second, third, and fourth lumbar nerves. It is of considerable size, and has a greater share than the others, in producing the uneasy sensations I have mentioned. 3d. Running parallel with the brim of the pelvis, but three quarters of an inch below it, in the cavity of the pelvis, is the obturator nerve, coming from the third lumbar, and which may be traced all along the side of the ilium to the thyroid hole. In many cases, it cannot fail, during labour, to be pressed on by the head. 4th. Beneath the vessels at the sacro-iliac junction, we have the great nerves which form the sciatic nerve, which is made up of the fourth and fifth lumbar nerves, and the first sacral nerve, which is as large as either of the former: to these are added the second and third sacral, which are much smaller. The fourth lumbar nerve passes down on the sacro-iliac junction, and is quite covered with the vessels. The fifth traverses that curved part of the sacrum, which lies betwixt its promontory and side; like the former, it is hid by the vessels. In going to form the sciatic nerve, the fourth lumbar nerve passes under the gluteal artery, or the common trunk of the



gluteal and ischiatic arteries, and the fifth passes over it. The first sacral nerve passes along the upper margin of the pyriform muscle, to join with these at the sacro-sciatic notch. There a large plexus is formed, which, uniting into a single trunk, passes out, and is the greatest nerve in the body. The lumbar nerves may be pressed on early in labour; but from the cushion of vessels and cellular substance which defends them, they suffer little. When the head has descended lower, and is beginning to turn, the first sacral nerve may be compressed. Pressure of the nerve produces pain, numbness, and cramp in the thigh and leg. Different nerves are acted on in different stages of labour. In the very beginning, the anterior crural nerve may be irritated or gently compressed, producing pain in the fore part of the thigh; next the obturator, producing pain in the inside; and last of all, the back part suffers from the pressure on the ischiatic nerve. 5th. The second and third sacral nerves are small, compared to the first. They are covered by the pyriformis muscle, but part of them pierce it, forming a plexus, which joins the sciatic nerve, and sends twigs to the bladder, rectum, &c. This plexus may be pressed in the last stage of labour; and the irritation thus produced may be one cause of the passage of the fæces, which generally takes place involuntarily. 6th. The fourth sacral nerve is altogether devoted to the extremity of the rectum, and its vicinity.

The great plexus, forming the sciatic nerve, as it lies in the sacro-sciatic notch, yields to any pressure it may receive, and cannot suffer in labour, at least, so as to cause inconvenience; but the nerves going to it may suffer, and the person not only have cramp and pain during labour, but palsy and lameness for a long time afterwards. Friction, and the warm bath, at first, may relieve the pain; and then, the cold bath may, with much advantage, be employed for perfecting the cure.

#### SECTION FOURTH.

The lymphatics in the upper part of the pelvis follow the course of the iliac vessels, forming a large and very beauti-

ful plexus, from Poupart's ligament to the lumbar vertebræ. These are out of the way of pressure during labour. Numerous glands accompany them, which are sometimes enlarged by disease, but they do not interfere with parturition. The lymphatics of the cavity of the pelvis have glands in the course of the vagina and rectum; and these, if enlarged, may impede delivery.

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## CHAP. IV.

### *Of the Dimensions of the Pelvis.*

#### SECTION FIRST.

THE pelvis has been divided into the great and the little, the first being formed by the expansion of the ilia, and the second, comprehending all that part which is called the cavity of the pelvis, and which lies below the linea ilio-innominata. The cavity of the pelvis is the part of the chief importance in Midwifery, and consists of the brim, or entrance, the cavity itself, and the outlet. The brim of the pelvis has no regular shape, but approaches nearer the oval than any other. The short diameter of this, extends from the symphysis of the pubis to the top of the sacrum. This has been called the conjugate, or antero-posterior diameter, and measures four inches. The lateral diameter measures five inches and a quarter; and the diagonal diameter, or a line drawn from the sacro-iliac symphysis to the opposite acetabulum, measures five inches and an eighth; but as the psoæ muscles, and iliac vessels, overhang the brim a very little at the side, the diagonal diameter, in the recent subject, appears to be the longest. From the sacro-iliac symphysis to the crest of the pubis, on the same side, is four inches and a half. From the top of the sacrum, to that part of the brim which is directly above the foramen thyroideum, is three inches and a half. The line, if drawn to the acetabulum, in place of the foramen, is a quarter of an inch shorter; a line drawn across the fore part

of the brim, from one acetabulum to another, is nearly four inches and a quarter.

The outlet of the pelvis is not so regular as the brim, in its shape, even when the soft parts remain; but it is somewhat oval. The long diameter extends from the symphysis pubis to the coccyx, and measures, when that bone is pushed back, as in labour, five inches, but an inch less when it is not. The transverse diameter, from the one tuberosity of the ischium to the other, measures four inches. The outlet of the pelvis differs materially from the brim, in this respect, that its margins are not all on the same level; an oval wire will represent the brim, but, if applied to the outlet, it must be curved. The outlet, from the symphysis pubis to the tuberosity of the ischium, is semi-oval; but behind, it becomes more irregular, and bends upwards and backwards. The arch of the pubis, or the fore part of the outlet, is four inches broad at its base; and a perpendicular line, dropped from its centre to the bone, is fully two inches long. The top of the arch will permit a circular body to come in contact with it, whose diameter is an inch and a quarter. The length of each limb of the arch is three inches and a quarter.

#### SECTION SECOND.

The cavity of the pelvis is the next part to be attended to; and the most important observation to be made, is, that it is of unequal depth. At the back part, it measures from five to six inches, according as the coccyx is more or less extended; at the side, a line drawn from the brim, to the tuberosity of the ischium, measures three inches and three fourths. At the fore part, the depth of the symphysis pubis is an inch and a half. When the surface of the child's head, then, is parallel to the lower edge of the symphysis, the head is still far from having entered fully into the cavity of the pelvis; it cannot be considered in the cavity, until it be lodged fairly in the hollow of the sacrum.

It may be proper to notice the dimensions of different parts of the cavity itself. An oblique line, drawn from the



sacro-iliac junction, on one side, down to the opposite tuberosity, measures six inches; and the long axis of the child's head, before it takes the turn forwards, corresponds to this line. From the ramus of the ischium, to the opposite sacro-iliac junction, is five inches. From the top of the arch of the pubis, or orifice of the urethra, to the second bone of the sacrum, is four inches and five eighths, to five inches. A line drawn from the top of the arch to the top of the sacrum, is about a quarter of an inch more than the antero-posterior diameter of the brim. From the top of the arch to the spine of the ischium, is three inches and a half. From the tuberosity of the ischium to the center of the sacrum is four inches. From the back part of the tuberosity to the sacro-iliac junction on the same side, is three inches and a half. From the extremity of the tuberosity to the spine of the ischium, is two inches. From the spine to the sacrum is two inches; and from the top of the arch of the pubis to the plane of the ischium, is two inches. The breadth of the plane itself is two inches; so that a line traversing these different parts, from the symphysis to the sacrum, would measure, including its slight irregularities, six inches. From the tuberosity to the inferior part of the thyroid hole, is an inch and a half. The long diameter of the sacro-sciatic notch, is two inches and three eighths; the short, one inch and three quarters.

In the living subject, we can readily recognize these different parts of the pelvis; and by the relation which one bears to the rest, we can ascertain, by careful examination with the finger, not only the relative position of the head with regard to any one spot, and consequently, its precise situation and progress in the pelvis, but also the shape and dimensions of the pelvis itself.

#### SECTION THIRD.

The shape, extent, and dimensions of the great pelvis, or that part which is above the brim, must be mentioned likewise, especially as these are of importance in estimating the deformity of a pelvis. From the symphysis pubis to the commencement of the iliac wing, at the inferior spinous pro-

cess, is nearly four inches. From the inferior spinous process to the posterior ridge of the ilium, a line subtending the hollow of the costa, measures five inches. The distance from the superior spine is the same. From the top of the crest of the ilium to the brim of the pelvis, a direct line measures three inches and a half. The distance betwixt the two superior anterior spinous processes of the ilium, is fully ten inches. A line drawn from the top of the crest of the ilium to the opposite side, measures rather more than eleven inches, and touches, in its course the intervertebral substance betwixt the fourth and fifth lumbar vertebræ. A line drawn from the centre of the third lumbar vertebra, counting from the sacrum to the upper spine of the ilium, measures six inches and three quarters. A line drawn from the same vertebra to the top of the symphysis, measures seven inches and three quarters, and, when the subject is erect, this line is exactly perpendicular.

To conclude my observations on the dimensions of the pelvis, I remark, that the shape is different in the child and the adult. The dimensions of the brim are reversed in these two states; the long diameter of the foetal pelvis, extending from the pubis to the sacrum. By slow degrees, the shape changes; and nearly about the time of puberty, the conjugate and lateral diameters are equal. When the female is fully perfected, the brim becomes more oval, the long diameter extending from one side to the other. If a girl should, very early, become a mother, the shape of the pelvis may occasion a painful and tedious labour.

#### SECTION FOURTH.

Finally, we are to remember that the brim, and the outlet of the pelvis, are not parallel to each other, but placed at a considerable angle. The axis of the brim will be represented by a line drawn from near the umbilicus, downwards and backwards, to the coccyx; that of the outlet, by a line drawn from the orifice of the vagina to the first bone of the sacrum. The precise points, however, which these lines will touch, must vary a little, according to the conformation

and obliquity of the pelvis, and the prominence of the abdomen. Each different part of the cavity of the pelvis has its own proper axis, and the line of motion of the child's head must always correspond to the axis of that part of the pelvis in which it is placed. A pretty good idea of this subject, with regard to labour, may be obtained, by placing a small catheter, of the usual curvature, in the axis of the brim, and making its extremity pass out at the axis of the outlet.

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## CHAP. V.

### *Of the Head of the Child, and its progress through the Pelvis in Labour.*

#### SECTION FIRST.

THE head of the child is made up of many different bones, and those of the cranium are very loosely connected together with membrane. The os frontis, temporal, parietal, and occipital bones, compose the bulging part of the cranium, and their particular shape regulates the direction of the sutures. The occipital bone is connected to the parietal bones, by the lambdoidal suture, which is readily discovered through the integuments, by its angular direction. The parietal bones are joined to the frontal bone, by the coronal suture, which is distinguished by its running directly across the head, and they are connected to each other by the sagittal suture, which runs in a direct line from the occipital, to the frontal bone; as the os frontis, in the fœtus, consists of two pieces, it can sometimes be easily traced with the finger, even to the nose. The upper and anterior angles of the parietal bones, and the corresponding corners of the two pieces of the frontal bone, are rounded off, so as to leave a quadrangular vacancy, which is filled up with tough membrane. This is called the great, or anterior fontanell, to distinguish it from another smaller vacancy at the posterior extremity of the sagittal suture, which is called the small fontanell. The first is known by its four corners, and by



its extending forward a little betwixt the frontal bones, and whenever it is felt, in an examination, we may expect a tedious labour; for the head does not lie in the most favourable position. The little fontanell cannot, during labour, be perfectly traced, as it is lost in the angular lines of the lambdoidal suture, which, however, ought to be readily discovered. The head is of an oblong shape, and its anterior extremity at the temples is narrower than the posterior, which bulges out at the sides by a rising of the parietal bones, called the parietal protuberances: from these the bones slope backwards, like an obtuse angle, to the upper part of the occiput, which is a little flattened, and is called the vertex. From these protuberances, the head also slopes downwards and forwards to the zygomatic process of the temporal bone, becoming, at the same time, gradually narrower.

#### SECTION SECOND.

The longest diameter of the head is from the vertex to the chin, and this is about five inches. From the root of the nose to the vertex, it measures four inches. From the one parietal protuberance to the other, a transverse line measures from three inches and a quarter, to three inches and a half. From the nape of the neck to the crown of the head, is three inches and a half. From the one temple to the other, is two inches and a half. From the occiput to the chin, along the base of the cranium, is four inches and a half. From one mastoid process to the other, along the base, is about two inches; from cheek to cheek is three inches. Although these may be the average dimensions of the head, yet, owing to the nature of the sutures, they may be diminished, and the shape of the head altered. The one bone may be pushed a little way under the other, and, by pressure, the length of the head may be considerably increased, whilst its breadth is diminished; but these two alterations by no means correspond, in a regular degree, to each other.

The size of the male head is generally greater than that of the female. Dr Joseph Clarke\*, an excellent practitioner.

er, upon whose accuracy I am disposed fully to rely, says, that it is a twenty-eighth or thirtieth part larger. It is a well established fact, that owing to the greater size of male children, women who have the pelvis in any measure contracted, have often a more tedious labour, when they bear sons than daughters; and many who have the pelvis well formed, suffer from the effects on the soft parts. Dr Clarke supposes, that one half more males than females are born dead, owing to tedious labour, or increased pressure on the brain; and owing to these causes, a greater number of males than females die, soon after birth. In twin cases, again, as the children are smaller, he calculates, that only one-fifth more males than females are still-born. Dr Bland\* says, that of eighty-four still-born children, forty-nine were males, and thirty-five, females.

#### SECTION THIRD.

By comparing the size of the head with the capacity of the pelvis, it is evident that the one can easily pass through the other. But I apprehend that the comparison is not always correctly made, for the child does not pass with the long diameter of its cranium parallel to a line drawn in the direction of the long diameter of the brim of the pelvis; but it descends obliquely, so that less room is required. The vertex naturally passes first, the chin being placed on the breast of the child. Now, the length of a line drawn from the nape of the neck, to the crown of the head, is three inches and a half; a line intersecting this, drawn from the one parietal protuberance to the other, measures no more. We have, therefore, when the head passes in natural labour, a circular body going through the brim, whose diameter is not above three inches and a half; and therefore, no obstacle or difficulty can arise from the size of the pelvis. There is so much space superabounding betwixt the pubis and sacrum, as to prevent all risk of injury from pressure on the bladder, urethra, or rectum; and as the long diameter of the head is descending obliquely, the sides of the brim of the

\* Phil. Trans. Vol. LXXI.

pelvis are not pressed on. This is so certainly the case, that the head may, and actually often does pass, without any great additional pain or difficulty, although the capacity of the pelvis be a little contracted. But when the shoulders, which measure five inches across, come to pass, then the brim is completely occupied. If, however, any contraction should take place in the lateral diameter, the child would still pass, the one shoulder descending obliquely before the other.

It is of great consequence to understand the passage of the child's head in natural labour; for upon this depends our knowledge of the treatment of difficult labour. The head naturally is placed with the vertex directed to one side, or a little towards the acetabulum; and the forehead, owing chiefly to the action of the promontory of the sacrum, is turned in the same degree, towards the opposite sacro-iliac junction. When labour begins, and the head comes to descend, the chin is laid on the sternum, and the vertex is directed downwards, nearly in the axis of the brim of the pelvis. When, by the contraction of the uterus, the head is forced a little lower, its apex comes to touch the plane of the ischium. Upon this the side of the vertex slides downwards and forwards, as on an inclined plane, the head being turned gradually, so that, in a little time, the face is thrown into the hollow of the sacrum\*, and the vertex presents at the orifice of the vagina. This is not fully accomplished, till the cranium has got entirely into the cavity of the pelvis. As the basin is shallow at the pubis, the head is felt near the orifice of the vagina, and even touching the labia and perineum, before the turn is completed, and when the ear is still at the pubis. The whole of the cavity of the pelvis is so constructed, as to contribute to this turn, which is further assisted by the curve of the vagina, and the action of the lower part of the uterus, on the head of the child. The head, whilst its long diameter lies transversely, continues to descend in the axis of the brim of the pelvis; but when it is turned, it passes in the axis of the outlet. When the turn

\* Dr O'Leary attributes this turn to the action of the spines of the ischia, on the two parietal bones, but not on opposite spots.



is making, the direction of the motion is in some intermediate point; and this fact should, in operating with instruments, be studied and remembered. When the pelvis is narrow above, and the sacrum projects forward, the vertex is long of reaching the inclined plane of the ischium; and when the head is lengthened out, so as to come in contact with it, we find, that although the projection of the sacrum directs the vertex sometimes prematurely a little forward, yet, the tendency to turn fully, is resisted by the situation of the bones above; a great part of the cranium, and all the face, being above the brim, and perhaps in part locked in the pelvis. By a continuation of the force, the shape of the head may be altered; even the vertex may be turned a little to one side, its apex not corresponding exactly to the extremity of the long diameter of the head; the integuments may be tumefied, and a bloody serum be effused between them, so as greatly to disfigure the presentation. As, therefore, in tedious labour, occasioned by a deformed pelvis, the skull may be much lengthened and misshapen, we are not to judge of the situation of the head, by the position of the apex of the tumour which it forms; but we must feel for the ear, which bears a steady relation to that part of the head which presents the obstacle. The back and upper part of the head are compressible, but the base of the skull and the face are firm. A line drawn from the neck to the forehead, passing over the ear, is to be considered as the boundary betwixt these parts of opposite character; and therefore we attend to the relative situation of the ear, as it ascertains both the position of the head, and its advancement through the brim.

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## CHAP. VI.

### *Of Diminished Capacity, and Deformity of the Pelvis.*

#### SECTION FIRST.

THE pelvis may have its capacity reduced below the natural standard, in different ways. It may be altogether

upon a small scale, owing to the expansion stopping prematurely, the different bones, however, being well formed, and correct in their relative proportions and distances. This may occasion painful labour, but rarely causes such difficulty as to require the use of instruments. Sometimes the bones are all of their proper size, but the sacrum is perfectly straight, by which, although both the brim and outlet are sufficiently large, yet the cavity of the pelvis is lessened; or when all the other parts are natural, the spines of the ischium may be exuberant, encroaching on the lower part of the pelvis.

Another cause of diminished capacity, is the disease called rickets, in which the bones in infancy are defective in their strength, the proportion of earthy matter entering into their composition being too small. In this disease, the long bones bend, and their extremities swell out; the pelvis becomes deformed, the back part approaching nearer to the front, and the relative distance of the parts being lost. The distortion may exist in various degrees. Sometimes the promontory of the sacrum only projects forward a very little more than usual, or is directed more to one side than the other<sup>1</sup>: and the curvature of the bone may be either increased or diminished. If the sacrum project only a little, without any other change, the capacity of the brim alone is diminished; but if the curvature be at the same time smaller than usual, the cavity of the pelvis is lessened: but unless the ischia approach nearer together, or the lower part of the sacrum be bent forward, the outlet is unaffected; and in most cases of moderate deformity, the outlet is not materially changed. In greater degrees of the disease, the anterior part of the brim becomes more flattened, the linea iliopectinea forming a small segment of a pretty large circle. The sacrum forms part of a concentric circle behind; and thus the brim of the pelvis, instead of being somewhat oval, is rendered semicircular or crescentic, and its short diameter is sometimes reduced under two inches. The promontory of the sacrum may either correspond to the symphysis pubis, or may be directed to<sup>2</sup> one side, rendering the shape of the

brim more irregular, and the dimensions smaller on one side than the other. In some instances, the shape of the brim is like an equilateral triangle; and although the diameter from the pubis to the sacrum be not diminished, yet the acetabula being nearer the sacrum, the passage of the head is obstructed.

#### SECTION SECOND.

THE pelvis is likewise, especially in manufacturing towns, sometimes distorted by malacosteon, or softening of the bones of the adult. This is a disease which sometimes begins soon after delivery, and very frequently during pregnancy. It is, indeed, comparatively rare in those who do not bear children, and it is always increased in its progress by gestation. It must be carefully attended to, for, to a negligent practitioner, it has at first very much the appearance of chronic rheumatism. It very generally begins with pains about the back, and region of the pelvis. These pains are almost constant, or have little remission. They are attended with increasing lameness, loss of flesh, weakness, and fever; but the distinguishing mark is diminution of stature, the person gradually becoming decrepid. In malacosteon, the pelvis suffers, but the distortion is generally different from that produced by rickets; for whilst the top of the sacrum sometimes sinks lower in the pelvis, and always is pressed forward<sup>3</sup>, the acetabula are pushed backwards and inwards, towards the sacrum and towards each other<sup>1</sup>; so that, were it compatible with life, for the disease to last so long, these parts would meet in a common point, and close up the pelvis, or at least convert its cavity to three slits. The ossa pubis form a very acute angle; so that the brim of the pelvis, instead of being a little irregular as in slight cases of rickets, or semicircular as in the greatest degree of that disease, consists, when malacosteon has continued long, of two oblong spaces on each side of the sacrum, terminating before, in a narrow slit, formed betwixt the ossa pubis<sup>5</sup>. In this narrow space, when the woman is advanced in her pregnancy, the urethra lies, and the bladder rests upon



the pendulous belly ; so that, if it be necessary to pass the catheter, we must sometimes use one made of elastic materials, or a male catheter, directing the concavity of the instrument towards the pubis. If the instrument be large, and the ossa pubis very near each other, it may be jammed betwixt them, if it be incautiously introduced. In this disease, as well as in rickets, it is to be remembered, that the promontory of the sacrum may overhang the contracted brim, so as more effectually to prevent the head from entering it.

Rickets being a disease, which is at its greatest height in infancy, we have not at present to consider the treatment. Malacosteon is, on the contrary, a disease of the adult ; and it would be of great importance to child-bearing women, to know how to check its progress. But the means capable of doing this with any tolerable degree of certainty, have not yet been discovered. As gestation uniformly increases the disease, it is proper that the woman should live *absque marito*. As there is evidently a deficiency of earth in the bones, it has been proposed to give the patient phosphate of lime, but little advantage has been derived from it ; and indeed, unless we can change the action of the vessels, it can do no good to prescribe any of the component parts of bone. We have, in the present state of our knowledge, no means of rendering the action more perfect, otherwise than by endeavouring to improve the general health and vigour of the system, by the use of tonics ; the cold bath, and attending to the state of the bowels. Anodyne frictions, and small blisters, sometimes relieve the pain \*.

#### SECTION THIRD.

The pelvis may be well formed externally, and yet its capacity may be diminished within, by exostosis from some of

\* Upon the subject of deformity of the pelvis, and for tables of many particular instances of distortion, I have great pleasure in referring the reader to the works of Dr Hull, a practitioner of sound judgment, and extensive knowledge.

the bones ; or it may be affected in consequence of the fracture of the acetabulum, from which I have seen extensive and pointed ossification stretch for nearly two inches into the pelvis ; or steatomatous or schirrous tumours may form in the pelvis, being attached to the bones or ligaments, of which I have known examples<sup>6</sup>. An enlarged ovarium<sup>7</sup>, or vaginal hernia<sup>8</sup>, may also obstruct delivery, even so much as to require the crotchet ; and therefore, although they be not indeed instances of deformed pelvis, yet as they diminish the capacity of the cavity, as certainly as any of the former causes which I have mentioned, it is proper to notice them at this time †. Enlarged glands in the course of the vagina, polypous excrescences about the os uteri or vagina, schirrus of the rectum, and firm encysted tumours in the pelvis, may likewise afford an obstacle to the passage of the child. Some tumours, however, gradually yield to pressure, and disappear until the child be born ; others burst, and have their contents effused in the cellular substance. A large stone in the bladder may also be so situated during labour, as to diminish very much the cavity of the pelvis ; and it may be even necessary to extract the stone before the child be delivered.

#### SECTION FOURTH.

In order to ascertain the degree of deformity, and the capacity of the pelvis, different instruments have been invented. Some of these are intended to be introduced within the pelvis, and others to be applied on the outside, deducting a certain number of inches for the thickness of the pubis, sacrum, and soft parts. But these methods are so very uncertain, that I do not know any person who makes use of them in practice. The hand is the best pelvimeter, and must in all cases, where an accurate knowledge is necessary, be introduced within the vagina. By moving it about, and observing the number of fingers which can be passed into different parts of the brim, or the distance to which two

† In all cases of moveable tumours, as well as in stone in the bladder, it is evident, that they ought, in the very beginning of labour, to be pushed above the brim, and prevented from entering it before, or along with the head.

fingers require to be separated in order to touch the opposite points of the brim, or the space over which one finger must move in order to pass from one part to another, we may obtain a sufficient knowledge, not only of the shape of the brim, cavity, and outlet of the pelvis, but also of the degree to which the soft parts within are swelled, as well as of the position and extent of any tumour which may be formed in the pelvis. We may be farther assisted by observing, that in great degrees of deformity or contraction, the head does not enter the brim at all; in smaller degrees it engages slowly, and the bones of the cranium, form an angle more or less acute, according to the dimensions of the brim, into which it is squeezed.

As in many cases of deformed and contracted pelvis, it is necessary to break down the head in order to get it through the cavity, it will be proper to subjoin the dimension of the foetal head when it is reduced to its smallest size. When the frontal, parietal, and squamous bones are removed, which is all that we can expect to be done in a case requiring the crotchet, we find that the width of the base of the cranium, over the sphenoid bone, is two inches and a half. The distance from cheek to cheek is three inches. From the chin to the root of the nose is an inch and a half; and by separating the symphysis of the jaw, the two sides of the maxilla may recede, so as to make this distance even less. From the chin to the nape of the neck, when the chin is placed on the breast, is two inches and three quarters. When, on the contrary, the chin is raised up, and the triangular part of the occiput laid back on the neck, the distance from the throat to the occiput is two inches. The smallest part of the head, then, which can be made to present, is the face; and when this is brought through the brim, the back part of the head and neck may, although they measure two inches, be reduced by pressure so as to follow the face. The short diameter of the chest when pressed, is an inch and a half; that of the pelvis is the same. The diameter of the shoulder is one inch.



## CHAP. VII.

*Of Augmented Capacity of the Pelvis.*

A very large pelvis<sup>1</sup>, so far from being an advantage, is attended with many inconveniences, both during gestation and parturition. The uterus, in pregnancy, does not ascend at the usual time out of the pelvis, which produces several uneasy sensations; it is even apt, owing to its increased weight, to be prolapsed: or, if the bladder be distended, it may readily be retroverted. At the very end of gestation, the uterus may descend to the orifice of the vagina; and, during labour, forcing pains are apt to come on before the os uteri be properly dilated, by which both the child and the uterus may be propelled, even out of the vagina; and in many instances, although this should not happen, yet the pains are severe and tedious, especially if the practitioner be not aware of the nature of the case.

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 CHAP. VIII.
*Of the External Organs of Generation.*

## SECTION FIRST.

THE symphysis of the pubis, and insertion of the recti muscles, are covered with a very considerable quantity of cellular substance, which is called the mons veneris. From this the two external labia pudendi descend, and meet together about an inch before the anus; the intervening space receiving the name of perinæum. On separating the great labia, we observe a small projecting body placed exactly on the lower part of the symphysis. This is the clitoris, and it is surrounded by a duplicature of skin called its prepuce. From this duplicature, or rather from the point of the clitoris, we find arising on each side, a small flap, which is continued down on the inside of the labia, to the orifice of the

vagina. These receive the name of nymphæ, or labiæ minores or interiores. On separating them, we observe, about nearly an inch below the clitoris, the extremity of the urethra; and, just under it, the orifice of the vagina, which is partly closed up, in the infant state, by a semilunar membrane called the hymen. These parts are all comprehended under the general name of vulva, or external organs of generation.

#### SECTION SECOND.

The labia have nothing peculiar in their structure, for they are merely duplicatures of the skin, rendered prominent by a deposition of fatty matter. Externally they have just the appearance of the common integuments; and at the age of puberty, are, together with the mons veneris, generally, covered with hairs. Internally they resemble the inside of the lips or eye-lids, and are furnished with numerous sebaceous glands. They are placed closer together below than above; and at their junction behind, a small bridle called the fourchette, extends across, which is generally torn whenever a child is born.

The nymphæ at first appear to be merely duplicatures of the inner surface of the labia, but they are, in fact, very different in their structure. They are distinct vascular substances, inclosed in a duplicature of the skin. When injected by filling the pudic artery, each nymphæ is found to be made up of innumerable serpentine vessels, forming an oblong mass. This at the upper part joins the clitoris, to which, perhaps, it serves as an appendage; whilst the loose duplicature of skin in which it is lodged, by being unfolded, permits the labia to be more safely and easily distended, during the passage of the child.

#### SECTION THIRD.

The clitoris is a small body resembling the male penis; but has no urethra. It consists of two corpora cavernosa, which arise from the rami of the ischia and pubis, and unite at the symphysis of the pubis. These are furnished with

two muscles analogous to the *erectores penis* of the male. When the *crura* and *nymphæ* are filled with wax, we find on each side, two vascular injected bodies, one of them in close contact with the bones, the other more internal with regard to the symphysis of the pubis. When the one is injected, the other is injected also, and both are connected together at the upper part. The clitoris, formed by the junction of its *crura*, is apparently about the eight part of an inch long, a part of it not being seen, and it is supported by a pretty strong suspensory ligament which descends from the symphysis. When distended with blood, it becomes erected and considerably longer, and is endowed with great sensibility.

#### SECTION FOURTH.

On separating the *nymphæ*, we find a smooth hollow or channel, extending down from the clitoris for nearly an inch; and at the termination of this, and just above the vagina, is the orifice of the urethra, which, although not one of the organs of generation, deserves particular attention. The bladder is lodged in the fore part of the pelvis, immediately behind the symphysis pubis; but when distended, it rises up, and its fundus has been known to extend even to the umbilicus. The urethra is the excretory duct of the bladder; it is about an inch and a half long, and passes along the upper part of the vagina, through which it may be felt like a thick fleshy cord. The structure of the urethra is extremely simple, for little can be discovered except the continuation of the internal coat of the bladder, covered with condensed cellular substance. On slitting up the canal, numerous mucous lacunæ may be discovered in its course, and two of these at the orifice are peculiarly large. The urethra is very vascular, and, when injected and dried, its orifice is perfectly red. In the unimpregnated state, it runs very much in the direction of the outlet of the pelvis; so that a probe, introduced into the bladder, and pushed on in the course of the urethra, would, after passing for about three inches and a half, strike upon the fundus uteri, and, if



carried on for an inch and a half farther, would touch the second bone of the sacrum. The uterus being much connected with the bladder at its lower part, it follows, that when it rises up in pregnancy, the bladder will also be somewhat raised, and pressed rather more forwards; and the vagina being elongated, the urethra, which is attached to it, is also carried a little higher, and, in its course, is brought nearer the inside of the symphysis pubis. In those women who, from deformity of the pelvis, or other causes, have a very pendulous belly, the bladder, during pregnancy, is sometimes turned over the pubis, the urethra curved a little, and its opening somewhat retracted within the orifice of the vagina. When it is necessary to pass the catheter, it is of great consequence to be able to do it readily, and this is by no means difficult to do. The woman ought to be placed on her back, with her thighs separated, and the knees drawn a little up: A bason is then to be placed betwixt the thighs, or a bladder may be tied firmly to the extremity of the catheter, to receive the urine. The instrument is then to be conveyed under the thigh, and the labia separated with the finger. The clitoris is next to be touched, and the finger run gently down the fossa that leads to the orifice of the urethra, which is easily distinguished, by its resemblance to an irregular dimple, situated just above the entrance to the vagina. The point of the instrument is to be moved lightly down the fossa after the finger, and it will readily slip into the urethra. It is then to be carried on in the direction of the axis of the outlet of the pelvis, and the urine drawn off. This operation ought always to be performed in bed, and the patient is never to be exposed. In cases of fractures, bruises, &c. where the woman cannot turn from her side to her back, the catheter may be introduced from behind, without moving her. When the bladder is turned over the pubis, as happens in cases of great deformity of the pelvis, it is sometimes requisite to use either a flexible catheter, or a male catheter, with its concavity directed forward. When the uterus is retroverted, if we cannot use a female catheter, we may employ a male catheter, directing the con-

cavity backwards. When the head of the child in labour has entered the pelvis, the urethra is pushed close to the symphysis of the pubis; then the flexible or flat catheter must be introduced parallel to the symphysis, and the head of the child may be raised up a little with the finger. This, indeed, of itself, is sufficient to allow the urine to flow; and when the urine is retained after delivery, it is often sufficient to raise up the uterus a little with the finger.

#### SECTION FIFTH.

The orifice of the vagina is situated nearly opposite to the anterior part of the tuberosity of the ischium, about an inch and a half below the symphysis of the pubis, and in the direction of the axis of the outlet of the pelvis. It is, in all ages, but more especially in infancy, considerably narrower than the canal itself, and is surrounded by a sphincter muscle, which arises from the sphincter ani, and is accompanied with a vascular plexus, called *plexus retiformis*. In children, it is always shut up by a membrane called the hymen, which consists of four angular duplicatures of the membrane of the vagina; the union of which may be discovered by corresponding lines on the hymen. At the upper part there is a semilunar vacancy, intended for the transmission of the menses. Sometimes it is imperforated, or partially or totally absorbed. When the hymen is ruptured, it is supposed to shrivel into three or four small excrescences at the orifice of the urethra, called the *carunculæ myrtiformes*.

Immediately below the orifice of the vagina, there is a short sinus within the labia, which extends farther back than the vagina. This has been called the *fossa navicularis*, and reaches to the fourchette.

## CHAP. IX.

*Of the Internal Organs of Generation.*

## SECTION FIRST.

THE internal organs of generation consist of the vagina, with the uterus and its appendages.

The vagina is a canal, which extends from the vulva to the womb. It consists principally of a spongy cellular substance, endowed with some elasticity, and having an admixture of indistinct muscular fibres. It is lined by a continuation of the cutis from the inner surface of the labia; and this lining, or internal coat, forms numerous wrinkles, or transverse rugæ, on the anterior and posterior sides of the vagina. They are peculiar to the human female, and are most distinctly seen in the virgin state; but after the vagina has been distended, they are more unfolded, and sometimes the surface is almost smooth. In the whole course of this coat, may be observed the openings of numerous glandular follicles, which secrete a mucous fluid. In the foetus this is white and milky; in the adult it is nearly colourless. The vagina is very vascular; and when the parts are well injected, dried, and put in oil of turpentine, the vessels are seen to be both large and numerous. Just below the symphysis pubis, we observe a great congeries of vessels surrounding the urethra and upper part of the vagina.

The vagina forms a curved canal, which runs very much in the course of the axis of the outlet and cavity of the pelvis. It is not round, but considerably flattened; it is wider above than below, being in young subjects much contracted about the orifice. At its upper part, it does not join the lips of the os uteri directly, but is attached a little above them, higher up behind than before, so that the posterior lip of the uterus is better felt than the anterior. In the infant, the vagina is attached still higher up, so that the lips of the uterus project in it something like a penis.



The inner coat of the vagina is reflected over the lips of the uterus, and passes into its cavity, forming the lining of the uterus. The junction of the uterus and vagina is so intimate, that we cannot make an accurate distinction betwixt them; but may say, that the one is a continuation of the other. The vagina adheres before very intimately to the urethra, behind, it comes gradually to approach to the rectum, and at its upper part it is pretty firmly connected to it. This union forms the recto-vaginal septum. These connections of the vagina are formed by cellular substance, there being only a very small part of its upper extremity covered with peritoneum.

When the finger is introduced into the vagina in situ, the urethra is felt on its fore part, resembling a firm fleshy cylinder. Behind, the rectum can be traced down to the point of the coccyx. At the side, the ramus of the ischium and of the pubis, together with the obturator internus muscle are to be distinguished. In a well formed pelvis, the finger cannot easily reach beyond the lower part of the sacrum; during labour, however, the parts being more relaxed, the bone may be felt more easily, but its promontory cannot be touched with the finger.

#### SECTION SECOND.

The uterus is a flat body, somewhat triangular in its shape, being considerably broader at its upper than at its under part. It is scarcely three inches in length, about two inches broad above, and one below. It is divided by anatomists into the fundus or upper part, which is slightly convex, and lies above the insertion of the fallopian tubes; the cervix or narrow part below; the body, which comprehends all the space betwixt the fundus and cervix; and last of all, the os uteri, which is the termination of the cervix, and consists of a small transverse ring, the two sides of which have been called the lips of the uterus. The uterus contains a small cavity of a triangular shape, which opens into a narrow channel formed in the cervix, and is continued down to the os uteri. At the upper angles may be perceived the openings

of the fallopian tubes. Both the cavity and the channel are lined with a continuation of the inner coat of the vagina, but it has a very different appearance from that which it exhibits in the vagina. The surface of the triangular cavity is smooth, and the skin which covers it is very soft and vascular. The surface of the cervical channel again is rugous, and the rugæ are disposed in a beautiful foliated manner, so as to have some resemblance to a palm tree. This part is by no means so vascular as the cavity above; but it contains betwixt the rugæ several lacunæ, which secrete a mucous fluid. Where the cavity of the uterus terminates in the channel of the cervix, there is sometimes a slight contraction of the passage.

The substance of the uterus is made up of numerous fibres, disposed very irregularly, and having a considerable quantity of interstitial fluid interposed, with many vessels ramifying amongst them. A dense succulent texture is thus formed, which constitutes the substance of the uterus. On cutting open the womb, we observe that its sides are about a quarter of an inch thick, but are rather thinner at the fundus, than elsewhere, though the difference is very trifling. Several irregular apertures may be perceived on the cut surface: these are the venous sinuses. The fibres which we discover are muscular; but we cannot, in the unimpregnated state, observe them to follow any regular course.

The arteries of the uterus are four in number, with corresponding veins. The two uppermost arteries arise either high up from the aorta, or from the emulgent arteries. They descend, one on each side, in a serpentine direction behind the peritoneum, and are distributed on the ovaria, tubes, and upper part of the uterus. These are called spermatic arteries. The two lowermost, which are called uterine, arise from the hypogastric arteries. They run, one on each side, toward the cervix uteri, and supply it and the upper part of the vagina. Thus the fundus uteri is supplied by the spermatic arteries, and the cervix, by the uterine arteries; and these, from opposite sides, send across branches which communicate one with the other. But besides this



distribution, the uterine artery is continued up the side of the uterus, and meets with the spermatic; so that, at the two sides, we have arterial trunks, from which the body of the uterus is liberally supplied with blood. The veins correspond to the arteries. The nerves of the uterus, like the blood vessels, have also a double origin, and follow nearly the same course. Those which come from below are derived from the sacral nerves, especially from the fourth pair. Those from above come chiefly from the mesocolic plexus, and trunk of the intercostal. The renal plexus furnishes nerves to the ovarium.

The lymphatics, in the unimpregnated state of the uterus, are small, and not easily discovered. Those from the upper part of the womb, and from the ovaria, run along with the spermatic vessels, terminating in glands placed by the side of the lumbar vertebræ. Hence, in diseases of the ovaria, there may be both pain and swelling of the glands. But the greatest number of lymphatics run along with the uterine artery, several of them passing to the iliac and sacral glands, and some accompanying the round ligament. This may explain why, in certain conditions of the uterus, the inguinal glands swell. Others run down through the glands of the vagina; and hence, in cancer of the womb, we often feel those glands hard and swelled, sometimes to such a degree, as almost to close up the vagina.

The uterus is covered with the peritonæum, which passes off from its sides, to reach the lateral part of the pelvis, a little before the sacro-iliac symphysis; and these duplicatures, which, when the uterus is pulled up, seem to divide the cavity of the pelvis into two chambers, are called very improperly the broad ligaments of the uterus.

When the uterus is raised, and those lateral duplicature of the peritonæum are stretched out, we observe, that at the upper part they form two transverse folds or pinions, one before, and the other behind. In the first of these, the fallopian tubes are placed; in the second, the ovaria.

Besides these duplicatures, we likewise remark other two, which extend from the sides of the fundus uteri to the linea



ilio-pectinea at the side of the pelvis, and then run on to the groin. These contain, on each side, a pretty thick cord, which arises from the fundus uteri, and passes out at the inguinal canal, being then lost in the labia pudendi. These cords, which are called the round ligaments of the uterus, consist of numerous blood-vessels, some lymphatic, small nerves, and fibrous matter.

The fallopian tubes, in quadrupeds, are merely continuations of the horns of the uterus; but in the human female, they are very different in their structure from the womb. They appear to consist in a great measure of spongy fibrous substance, which, as Haller observes, may be inflated like the clitoris. This is hollow, forming a canal of about three inches long, lined with a continuation of the internal coat of the uterus; and as they lie in the anterior pinion of the broad ligaments of the uterus, they are covered of necessity with a peritoneal coat. They originate from the upper corners of the uterine cavity by very small orifices, but terminate at the other extremity in an expanded opening with ragged margins, which are called the fimbriæ of the tube. The internal surface of the canal is plaited, the plicæ running longitudinally.

The ovaria<sup>1</sup> lie in the posterior pinion of the broad ligament. They are two oval flattened bodies, of a whitish colour, and glandular consistence. They are cellular, but not very vascular, although vessels run to their coat. After puberty, they contain numerous minute vesicles, the largest of which are near the surface, and even form slight projections from it. These are the ova of the female, and are filled with a coagulable lymphatic matter. Their number is uncertain, but Haller says he never saw above fifteen in one woman. In old women they disappear, or shrivel.

The ovarium is covered with the peritoneum; but when the ovum is impregnated and becomes prominent, the peritoneum which covers it is absorbed, the ovum passes into the fallopian tube, and the little scar which remains on the surface of the ovarium, is called corpus luteum.

In the fœtus, the ovaria and tubes are placed on the posæ

muscles; but in the adult, they lie loosely on the pelvis, and the uterus sinks within the cavity. The os uteri is directed forward, and the fundus backward, being in general found opposite to, or resting on the second bone of the sacrum.

## CHAP. X

### *Of the Diseases of the Organs of Generation*

#### SECTION FIRST.

THE labia are subject to several diseases: of these, the first which I shall mention, is phlegmonoid inflammation. This may occur at any period of life, and under various circumstances; but frequently it takes place in the pregnant state, especially about the sixth and seventh month of gestation, and sometimes it appears suddenly, oftener than once in the same pregnancy; occasionally it makes its attacks in child-bed, in consequence of the violence which the parts may have sustained in labour. It is marked by the usual symptoms of inflammation, namely, heat, pain, throbbing, and more or less swelling, not unfrequently attended with fever. The swelling is sometimes hard and moveable, like a gland, especially when the progress is slower than usual. In general, the course of the disease is rapid, the pain and inflammation are at first very acute, and the part swells speedily. In a few hours, especially if a poultice have been applied, the abscess begins to point at the inside of the labium, and the nymphæ is either lost, or if it remain, appears pushed out of its place. Sometimes it bursts within thirty-six hours from its appearance. By means of cold saturnine applications, and gentle laxatives, the inflammation may sometimes be resolved, but most frequently it ends in suppuration, which is to be promoted by fomentations and warm cataplasms. If necessary, an opiate may be given to abate the pain, and a pillow must be placed between the knees, to keep the part from pressure. If possible, the ab-

scess ought not to be punctured, but, if the pain and tension be unbearable, we must indulge the patient by making a small opening; a good deal of blood will in this case come with the matter. After the abscess bursts, the parts may be dressed with any mild ointment. Should the opening of the abscess be higher than its bottom, it will be necessary, if the discharge continue\*, to lay it open, after which it will speedily heal.

#### SECTION SECOND.

The internal surface of the labia is often the seat of ulceration and excoriation, which may generally be avoided by the daily use of the bidet. The most general form under which excoriation appears, is that of a raw surface, as if the cuticle had been peeled from a blistered part. Most frequently these sores are the consequence of acrimony, produced by inattention to cleanliness, especially in children; and in their case the labia, if care be not taken, may cohere. The treatment consists in keeping the parts clean, bathing the sore with a weak solution of sulphate of zinc, and preventing cohesion. Should the parts not heal readily, they may be washed with brandy, or a very weak solution of nitrate of silver, or touched with caustic. When adhesion takes place, it may, if slight, be destroyed, by gently pulling the one labium from the other; if firmer, the parts must be separated with the knife. In either case, reunion must be prevented, by washing the surface frequently with solution of alum, and applying a small piece of lint spread with simple ointment. Simple itching of the parts may be removed by the tepid bath, a dose of castor oil, and fomenting the parts with milk and water.

Sometimes we meet with deeper ulcerations, which it is of great importance to the domestic happiness of individuals to distinguish from chancre. Nothing seems easier in a book, than to make the diagnosis, but in practice it is often very difficult. A well marked chancre begins with circumscribed inflammation of the part; then a small vesicle forms, which

\* Vide Mr Hey's Surgical Observations, p. 183.



bursts, or is removed by slough, and displays a hollow ulcer, as if the skin had been scooped away or nibbled by a small animal; its surface is not polished, but rough, and covered with pus, which is generally of a buff or dusky hue; the margins are red, and the general aspect of the sore is angry. But the most distinguishing character of the chancre, is considered to be a thickening or hardness of the base and edges of the ulcer. The progress of the sore is generally slow, either towards recovery or augmentation. When remedies are used, the first effect produced is removing the thickening by degrees, and lessening the discharge, or changing its nature, so that the surface of the sore can be seen; it has then in general a dark fiery look, which continues until all the diseased substance be removed, and the action of the part be completely changed. Now, from this description, we should, it may be supposed, be at no loss in saying, whether a sore were venereal; but in practice, we find many deviations from this description. The thickening may be less in one case than another, and may not be easily discovered, yet the sore may be certainly venereal. Peculiarity of constitution, or of the part affected, can modify greatly the effects of the virus. There may be extensive inflammation, or phagedænic ulceration: and yet the action may be venereal. It is, however, satisfactory to know in these cases, that in a little time, unless extensive sloughing have taken place, the appearance of the sore becomes more decided, the proper character of chancre appears, and the usual remedy cures the patient.

Phagedæna is a very troublesome, and sometimes a formidable disease, especially to infants. I shall here only notice that form which appears in adults, and which, as it is infectious, may be mistaken for syphilis. It commences with a livid redness of the part, succeeded speedily by vesication and ulceration, which extends laterally, and sometimes penetrates deep. The ulcer has an eating appearance, is painful, discharges a great quantity of matter, and very often is attended with fever. A variety of this disease is attended with superficial sloughing, which may be frequently repeat-

ed, and is generally preceded by a peculiar appearance of cleanness in the sore. This is not to be confounded with sloughing, produced by simple inflammation or irritation of the parts, which is similar in its nature and treatment to common gangrene. We must foment the sore with decoction of camomile flowers, mixed with a little tincture of opium, and then apply mild dressings. Rest is essential to the cure: and if a febrile state exist, it is to be obviated by laxatives, acids, mild diaphoretics, and decoction of bark. If there be no fever, mercury, or the nitrous acid, often effectually change the action of the parts.

Sometimes irritable sores appear on different parts of the labia, or orifice of the vagina, in succession, healing slowly one after another. These have an inflamed appearance, the margins are sometimes tumid, and the surface is at first irregular and depressed, but afterwards it forms luxuriant granulations. There is another sore met with on the inside of the labium, and which generally spreads to the size of a sixpence. The surface is quite flat, and sunk a little below the level of the surrounding parts. The margins are thickened, and sometimes callous, the discharge thin, and the ulcer not in general painful, the surface soft and spongy without a hard base. These sores generally agree best with stimulants, especially caustic and escharotics. When they do not yield to this treatment, it will be proper to have recourse to a cautious course of mercury. Some of these, like the phagedæna, are infectious.

Some of these sores are occasionally productive of secondary symptoms, such as ulcers in the throat. When these succeed a sore, which has run its course differently from chancre, and been healed without the use of mercury, it is allowable to suppose, that they also may be cured, merely by attending to the general health, and perhaps by local applications. But if they continue without amendment, or threaten danger to any important part, we must not delay making trial of mercury.

## SECTION THIRD.

Sometimes after a slight degree of inflammation, producing heat and itching of the parts, numerous excrescences appear within the labia. These are either soft and fungous, or hard and warty. Both of these states may be induced by previous venereal inflammation; but they may also occur independently of that disease. Even where there is an offensive discharge from the fungi or warts, we are not always to conclude that they are syphilitic, but must be guided in our judgment by concomitant circumstances. Warty excrescences are most readily removed, by the application of savin powder by itself, or mixed with red precipitate; and during its operation, the parts may be washed with lime water. The powder must be applied close to the roots of the warts, for their substance is almost insensible. Fungous excrescences may sometimes be removed by ligature; but when the parts are sensible, they must be destroyed, by applying a strong solution of caustic with a pencil, or sprinkling them with escharotic substances. If these cannot be born, we must first abate the sensibility by tepid fomentations with decoction of poppies, or water with a little tincture of opium, or decoction of cicuta, or weak infusion of belladonna. Should there be ground for suspecting a syphilitic action, mercury must be given, at the same time that we make suitable local applications; but in doubtful cases, I have seen this medicine given without any benefit. These excrescences, from their appearance, their great pain, and foetid discharge, may suggest an opinion of their being cancerous; but they begin in a different way, and generally yield, though sometimes slowly, to proper applications.

## SECTION FOURTH.

Solid tumours may form in the labia, and are distinguished by their hardness, and by their moving under the skin, until adhesion from inflammation takes place. These tumors are sometimes scrophulous and have little pain, even when they have gone on to suppuration. Oftener, however,



they are cancerous; and these are distinguished from the former, by their greater hardness and inequality, and by their shooting pain. If they are not removed, the cancerous abscess points to the inner surface of the labium, its top becomes dark coloured, sloughs off, a red fluid is discharged, and presently a fungus appears. Soon after this, the glands at the top of the thigh, and sometimes those in the course of the vagina, swell. If all the diseased parts can be removed, an operation must be performed. If they cannot, we must palliate symptoms by proper dressing and opiates.

#### SECTION FIFTH.

Soft fleshy appendiculæ, or firm polypous tumours sometimes spring from the labia. Both of these, especially the latter, may give trouble by their weight or size. They may also, by being fretted, come to ulcerate, and the ulceration is always of a disagreeable kind. They ought to be, therefore, early removed by the knife or the ligature. If the base be broad, the double ligature must be employed; but should there be any hardness about the part where the ligature would be applied, it is best to dissect the whole growth out.

Encysted tumours may form in the labia. They are elastic, and contain a glairy fluid. A seton may be passed, or the cyst may be laid open.

#### SECTION SIXTH.

Edematous tumour of the labium is either a consequence of pregnancy, or a symptom of general dropsy. The tumour is variable in its size. When it depends on pregnancy, it is seldom necessary to do any thing; and even in time of labour, although the tumour be great, we need be under little apprehension, for it will yield to the pressure of the child's head. But if at any time, during gestation, the distension be so great as to give much pain, then one or two punctures may be made, in order to let out the fluid, but this is very rarely necessary. Gentle laxatives are generally useful. Blisters applied to the vicinity of the part have been pro-

posed, but they are painful and inconvenient. When the swelling depends on dropsy, diuretics are to be employed; but if the woman be pregnant, they must be used cautiously.

#### SECTION SEVENTH.

Pudendal hernia is formed in the middle of the labium. It may be traced into the cavity of the pelvis, on the inside of the ramus of the ischium, and can be felt as far as the vagina extends. It differs farther from inguinal hernia, which also lodges in the labium, in this, that there is no tumour discoverable in the course of the round ligament from the groin. It sometimes goes up in a recumbent posture, or it may by pressure be returned. A pessary has little effect in keeping it up, unless it be made inconveniently large. It is not easy to adapt a truss to it, but some good is done with a firm T-bandage, or one similar to that used for prolapsus ani. If it cannot be reduced, we must support it by a proper bandage, which is not to be drawn tight.

Sometimes the labia are naturally very small, at other times uncommonly large; one side may be larger than the other.

Laceration of the labia is to be treated like other wounds. When the hemorrhage is great, the vagina must be plugged, and a firm compress applied externally, with a proper bandage.

#### SECTION EIGHTH.

The most frequent disease to which the nymphæ is subject, is elongation. When the part protrudes beyond the labia, it becomes covered with a white and more insensible skin. But sometimes it is fretted, on which account, or from other causes, women submit to have the nymphæ cut away. This is done at once by a simple incision; but, as the part is exceedingly vascular, we must afterwards restrain the hemorrhage, either with a ligature or by pressure. By neglect, the patient may lose blood, even *ad deliquium*. In some countries, this elongation of the nymphæ is very common.<sup>1</sup> In others, the nymphæ, together with the preputium

clitoridis, are removed in infancy.<sup>2</sup> The nymphæ are subject to ulceration, tumor, and other diseases, in common with the labia.

Sometimes by falls, but oftener<sup>3</sup> in labour, the vascular structure of the nymphæ is injured, and a great quantity of blood is poured out into the cellular substance of the labia, producing a black and very painful tumour.<sup>4</sup> This may take place even before the child is expelled; and, in a case of this kind, the midwife, mistaking this swelling for the protruded membranes, actually perforated the labium, and caused a considerable discharge of blood.<sup>5</sup> More frequently, however, the tumour appears immediately after delivery,<sup>6</sup> and the attention is directed to it both by its magnitude and its sensibility, which is sometimes so great as to cause syncope. It is tense, throbbing, and may also be accompanied by severe pain in the legs, and violent bearing down efforts,<sup>7</sup> as if another child were to be born, or, as if the womb were inverted. It has, however, been known to advance so slowly, as not to attract attention for two days. There are also instances where the inflammation runs high, and the recto-vaginal septum sloughing, fæces are discharged by the vagina.<sup>8</sup>

In the course of a short time the tumour bursts, and clotted and fluid blood is discharged. This process should be hastened by fomentations and poultices, and the pain be abated by opiates; but if it be very great, relief may be obtained, by making a small puncture in the inside of the labium.<sup>9</sup> Whether the tumor burst, or, be punctured, the previous inflammation may close the vessels so as to prevent hemorrhage; but if it do not, the vagina is to be gently filled with a soft cloth to prevent the fluid from extending along the sides of the pelvis. A compress is also to be firmly retained externally, to check all hemorrhage from the aperture. If inflammation run high, it is to be abated by the usual means.



## SECTION NINTH.

The clitoris may become scirrhus, and even be affected with cancerous ulceration. In this disease, it is generally thickened, enlarged,<sup>10</sup> and indurated, and the patient complains of considerable pain. Presently ulceration takes place, and fungus shoots out. In no case of this kind that I have met with, has an operation been submitted to; and, indeed, unless the whole of the diseased part can be removed, we must be satisfied with palliating symptoms. In one case, however, related by Kramer,<sup>11</sup> where the clitoris was enlarged, with cauliflower-like excrescences, and the right nymphæ indurated, the parts were successfully removed by the knife, after failing with the ligature, which produced insupportable pain.

The clitoris sometimes becomes preternaturally elongated; and if this take place in infancy, and be accompanied with imperfect or confused structure of the other parts, the person may pass for an hermaphrodite.<sup>12</sup> This is said to be most frequent in warm climates; and in these, extirpation is sometimes performed. Haller assigns a cause for the enlargement.

## SECTION TENTH.

The most frequent disease of the hymen is imperforation; in consequence of which the menses are retained,<sup>13</sup> the uterus is distended, and the orifice of the vagina protruded, so as sometimes to resemble polypus, or a prolapsus uteri.<sup>14</sup> Even the perinæum may be stretched, as if the head of a child rested on it.<sup>15</sup> Menstruation is generally painful, and the uterus becoming enlarged, contraction at last takes place, and pains like those of labour come on, especially about the menstrual period;<sup>16</sup> such a case may, therefore, by inattention, be mistaken for parturition.<sup>17</sup> The sufferings of the patient are, in some instances, increased by the addition of suppression of urine,<sup>18</sup> or pain in passing the fæces,<sup>12</sup>

or convulsions\*. Imperforated hymen is by no means uncommon, and the treatment is very simple, for the part is easily divided.<sup>20</sup> The retained fluid is thus evacuated, sometimes in very great quantity. It has very rarely the appearance of blood, being generally dark coloured, and pretty thick, or even like pitch. Febrile and inflammatory symptoms may follow the operation.<sup>21</sup>

The hymen is sometimes perforated as usual, but very strong, so as to impede the sexual intercourse; yet in those cases impregnation has taken place, and the hymen has been torn,<sup>22</sup> or cut in the act of parturition. Conception may take place, although the hymen be imperforated.†

When the hymen is torn in coitu, some blood is evacuated, which, in many countries, is considered as a mark of virginity. But as even the presence or absence of a hymen cannot be looked upon as affording any certain proof relative to chastity, this test must be considered as altogether doubtful. When the hymen is ruptured, and there is an inflammation about the external parts, some have, in cases of alleged rape, considered the crime as proved.‡ But whoever attentively examines the subject must admit, that these are very fallacious marks; that they may exist without any violence having been employed; and that a woman may have, if previously stupified, been violated without exhibiting any mark of injury. Practitioners therefore ought, in a legal question of this nature, to be cautious how they give any opinion, especially if they have not seen the person immediately after the crime has been committed.‡.

#### SECTION ELEVENTH.

The perinæum may be torn during the expulsion of the head or arms of the child. In many cases, the laceration does not extend farther back than to the anus, nor even so far. This is a very simple accident, and requires no other

\* Vide Case by Mr Fynney, in Med. Comment. Vol. III. p. 194.

† Vide Ambrose Pare, Hildanus, cent. III. ob. 60.—Ruysch, ob. 22.—Mauriceau, ob. 439.

‡ Vide Baudelocque, l'Art, &c. sec. 342, et Fodere Med. Legale, Tome II. p. 3.

management than rest, and attention to cleanliness. But as the recto-vaginal septum is carried forwards and downwards, when the perinæum is put on the stretch previous to the expulsion of the head, it sometimes happens, that the laceration extends along this septum, and a communication is formed betwixt the rectum and vagina. In some cases, the sphincter ani remains entire, although the rectum be lacerated; in others it also is torn. This accident is attended with considerable pain and hæmorrhage, and succeeded by an inability to retain the fæces, which pass rather by the vagina than the rectum. Prolapsus uteri is also, in some instances, a consequence of this laceration. This accident is sometimes produced by attempts to distend the parts previous to delivery, or by the use of instruments; but it may also take place, even to a great degree, in a labour otherwise natural and easy, and in which no attempts have been made to accelerate delivery. The most effectual way to prevent laceration is by supporting the perinæum with the hand, when it is stretched, and keeping the head from being suddenly forced out. When the parts have been actually torn, our first attention is to be directed to the repressing of the hæmorrhage, which is sometimes considerable; and this is best affected by compression and rest, which favour the formation of coagula. Next, we are to consider how the divided parts may be united. Rest, and retaining the thighs as much together as possible, together with frequent ablution, in order to remove the urine, which sometimes, for a few days flows involuntarily, or the lochia and stools, are requisites in every mode of treatment. As there is nothing in the structure of the parts to prevent their re-union, it has very feasibly been proposed to induce a state of costiveness, and prevent a stool for many days. But with only one or two exceptions, this method has failed; the subsequent expulsion of the indurated fæces tearing open the parts, if adhesion had taken place. An opposite practice, that of keeping the bowels open, and the stools soft or thin, by gentle laxatives, has been much more successful, the parts in some instances healing in a few weeks. During this pe-



riod, the stools are, at least for a time, passed sometimes involuntary ; but in other instances, they can from the first be retained, if the patient keep in bed. Sutures have been also employed, and ought certainly to be had recourse to, if re-union cannot otherwise be effected. If necessary, the edges of the divided parts must be made raw. It would appear that there is no occasion for putting a ligature in the recto-vaginal septum. It is sufficient to place two in the perinæum. When the sphincter ani remains entire, but the septum is torn, some have considered it necessary to divide that muscle ; but others, with more reason, omit this practice. During the cure, some introduce a canula into the vagina, to support the parts, and others apply compresses dipped in balsams ; but I believe it is better to apply merely a pledget, spread with simple ointment to the part. If the radical cure fail, the patient must use a compress, retained with a T-bandage<sup>25</sup>.

#### SECTION TWELFTH.

The vagina may be unusually small. I have known it not above three inches long, and sometimes it is very narrow. If the size prevent coition, it may be enlarged with a tent of prepared sponge\*. Should pregnancy take place before it be fully dilated, we need be under no apprehension with regard to delivery ; for during labour, or even long before it, relaxation<sup>24</sup> takes place. Sometimes the vagina is wanting or impervious, or all the middle portion of the canal is filled up with solid matter. More frequently, however, there is only a firm septum stretched across, behind the situation of the hymen, or higher up in the vagina ; and this<sup>25</sup> it may be necessary to divide. In some cases, there is a great confusion of parts, and, indeed, it is impossible to describe the varieties of conformation ; for the vagina may follow a wrong course, or communicate with the urethra, or the rectum<sup>26</sup> may terminate in the vagina, &c. Malformation does not always prevent pregnancy<sup>27</sup>.

\* Vide Van Swieten Comment in aph 1290.

## SECTION THIRTEENTH.

In consequence of very severe labour, inflammation, followed by gangrene, may take place in the vagina. If the sloughs be small, then partial contraction of the diameter of the canal may take place, and produce much inconvenience from retention of the menses<sup>28</sup>, or during a subsequent labour; but in this last case, the parts gradually yield, and it is seldom necessary to perform any operation: the pain, however, is sometimes excruciating till the part yields\*.

In some instances the sloughs are so extensive, that the whole vulva is destroyed, or part of the urethra and vagina comes away, or general adhesion takes place, leaving only a small opening, through which the urine and the menses flow. Should this, by any means be stopped up for a time, the discharges cannot take place; and sharp pains, or even convulsions, may be the consequence. Sometimes calculeous concretions form beyond the adhering part†.

Whenever we have reason to expect a tender state of the parts after delivery, we must be exceedingly attentive; and if the vagina, or any other organ, be inflamed or tender, we must bathe the parts frequently, and inject some tepid water gently, to promote cleanliness. Saturnine fomentations and injections are often of service, but they must not be thrown high. The urine must be regularly evacuated; and should a slough take place, we must, by proper dressings, or the use of a thick bougie, prevent coalescence of the vaginal canal<sup>29</sup>.

## SECTION FOURTEENTH.

The vagina may be contracted by scirrhus glands in its course, or induration of its parietes, which become thick and ulcerated, and communicate with the bladder or rectum. This disease is generally preceded by, or accompanied with, scirrhus uterus, and requires the same treatment.

\* Harvey, exercit. LXXIII. p. 492.

† Vide Puzos Traite, p. 140.—Case by Mr Purton, in Med. and Phys Jour, Vol. VI, p. 2.

Foreign bodies in the vagina may produce ulceration, and fungous excrescences. The source of irritation being removed, the parts heal; but we must, by dressing and injections, prevent coalescence.

Polypous tumours may spring from the vagina, and are to be distinguished from polypus of the uterus by examination. The diagnosis betwixt polypus and prolapsus, or *inversio uteri*, will be afterwards pointed out. The cure is effected by the application of the ligature *more solito*.

#### SECTION FIFTEENTH.

The vagina may be inverted or prolapsed, without a *proidentia uteri*. The nature of this disease is similar to *prolapsus ani*. We find a fleshy substance protruding at the back part of the vulva, having an opening in the centre, or toward one side. At first it is soft; but after sometime, if the part has been irritated, it may inflame, indurate, or ulcerate. It is cured by astringent injections, tonics, and, if these fail, by a pessary, or by pregnancy\*; but it sometimes returns after delivery<sup>50</sup>. In *prolapsus vaginæ*, the urethra must be turned out of its course, and even the bladder may be protruded<sup>51</sup>. If the catheter be required, it must be introduced with its point directed backwards and downwards.

#### SECTION SIXTEENTH.

Water sometimes passes down from the abdominal cavity, betwixt the vagina and rectum, protruding the posterior surface of the vagina in the form of a bag; and the accumulation of water in the cavity of the pelvis is sometimes so great, as to obstruct the flow of the urine, or produce strangury. When the person lies down, the swelling disappears. If large, a candle held on the opposite side, sometimes shews it to be transparent; and in every case, fluctuation may be felt. As this symptom is connected with *ascites*, the usual treatment of that disease must be pursued, and, if necessary, the water may be drawn off by tapping the abdomen, or ra-

\* Pechlin, lib. 1. obs. 20.



ther by piercing<sup>52</sup> the tumour, which is to be rendered tense, by pressing it with the finger.

#### SECTION SEVENTEENTH.

Sometimes the intestine passes down betwixt the vagina and rectum, forming perineal hernia, or protrudes either at the lateral or posterior part of the orifice of the vagina, like the watery tumour; but is distinguished from it by its firmer and more doughy feel, and by the manner in which it can be returned. By handling it, a gurgling noise may be heard, and sometimes indurated fæces may be felt. As the os uteri is pushed forward, and the posterior part of the vagina occupied by the herniary tumour, this complaint may put on some appearance of retroverted uterus. A case of this kind is mentioned by Dr John Sims, in Mr Cooper's work on hernia. This complaint is frequently attended with a bearing down pain; and on this account, as well as from its appearance, it has also been mistaken for prolapsus uteri. Sometimes the tumour does not protrude externally; but symptoms of strangulated hernia may appear, the cause of which cannot be known, unless the practitioner examine the vagina. In a case occurring to Dr Maclaurin, and noticed by Dr Denman, the patient died on the third day, and the disease was not discovered till the body was opened. Should a woman have vaginal hernia during pregnancy, we must be careful to return it before labour begin, for the intestine may become inflamed, and the fæces obstructed, by the head entering the pelvis; or the labour itself, if the head cannot be raised and the intestine returned, may be impeded so much, as to require the use of instruments. Vaginal hernia requires the use of a pessary.

The rectum sometimes protrudes into the vagina. This is remedied by the sponge or globe pessary.

#### SECTION EIGHTEENTH.

Indolent abscess, or encysted tumours, may form betwixt the vagina and neighbouring parts. These are distinguished from hernia and watery tumours, by being incompressible;

and not disappearing by change of posture. The history of the disease assists the diagnosis, and examination discovers the precise seat and connections of the tumour, though it cannot with certainty point out the nature of the contents. These tumours seldom afford obstinate resistance to delivery; by degrees they yield to the pressure of the head, but sometimes they return after delivery. The treatment is similar to that required in other cases of tedious labour, and the tumour should not be opened if we can deliver the woman otherwise. Even in the unimpregnated state, unless inconvenience be produced, we ought not to perform any operation; but if it cause irritation, or if the bulk of the tumor be so great as to impede the evacuation of the urine or feces, an opening must be made.

Varicose tumors of a knotted form, disappearing or becoming slack by pressure, and aneurismal tumors, distinguishable by their pulsation, may form about the vagina, and ought not to be interfered with, except by supporting them with a sponge in the vagina,

#### SECTION NINETEENTH.

A very dreadful disease, which I have called spongoid tumor, may form either within the pelvis, or about the hip joint, or tuberosity of the ischium, and spread inwards, pressing on the bladder and rectum, sometimes so much as to require the use of the catheter. We recognise the disease, by its assuming very early the appearance of a firm elastic tumor, as if a sponge were tied up tightly in a piece of bladder. Presently it becomes irregular, and the most prominent parts burst, discharging a red fluid, which is succeeded by fungous ulceration. But I have never known it proceed to this last stage within the pelvis. I know of no remedy, and would dissuade from puncturing, except in the very last extremity. I have never met with a case where it was necessary.

#### SECTION TWENTIETH.

The orifice of the vagina, together with the labia, and

indeed the whole vulva, may be affected by erysipelatous inflammation. This appears under two conditions: 1st, it may originate in the vulva, and spread inwards, even to the uterus; or, 2dly, it may begin in the womb, and extend outwards. The parts are tumid, painful, and of a dark red colour. The second affection is most frequent after parturition; but the first may occur at any age, and under a variety of circumstances. It may be confined to the external parts alone, or it may quickly spread within the pelvis, and destroy the patient; for this disease generally terminates in gangrene. Vigarous \* says, this state may be distinguished from abscess of the labium, by both labia being equally affected. The general history of the case, and proper examination, will point out the difference. When the disease is confined to the external parts, we may hope for a cure, and even for the preservation of the parts, by giving early, bark and opium internally, and applying to the surface pledgits dipped in camphorated spirit of wine, or vinous tincture of opium, made with half a dram of opium to each ounce of wine. When these applications give continued pain, fomentations with milk and water, or with decoction of chamomile flowers may be substituted.

A highly sensible or inflamed state of the parts may occur in nymphomania, or libidinous madness, either as a primary or secondary affection; and should the patient die under the disease, the parts are generally found black. The tepid bath and fomentations give relief, but sometimes spiritous applications are beneficial. If the patient be feverish, she ought to be bled, and have cathartics administered, and be put on spare diet. Nauseating doses of tartar emetic, or full doses of the medicine, given so as to operate briskly, are of service, especially if followed by sleep. Strict and prudent attention must be paid to the mind.

#### SECTION TWENTY-FIRST.

The vagina is always moistened with a fluid, secreted by

\* *Maladies des Femmes*, Tome II. p. 169.



the lacunæ on its surface. When this is increased in quantity, and changed in colour, it is known under the improper name of gonorrhœa. When this is unaccompanied with inflammation, and independent of the application of venereal matter, it has been called the benign gonorrhœa, or is considered as a species of fluor albus. Others confine the term fluor albus, or leucorrhœa, strictly to a discharge from the inner surface of womb; and in order to determine whether the secretion proceeds from the uterus or not, it has been proposed to stuff the vagina completely for some time, and then inspect the plug, to ascertain whether that part corresponding to the os uteri be moistened\*. But this test is not satisfactory, and will seldom be submitted to.

When the discharge proceeds from the womb, it sometimes injures the function of that organ so much, or is dependant on a cause influencing the uterus so strongly, as to interfere with menstruation, either stopping it altogether, or rendering it too abundant or irregular in its appearance, and in such cases the woman seldom conceives. Very frequently, however, the menses do continue pretty regularly; and in those cases, the white discharge disappears during the flow of the menses, but is increased for little before and after menstruation. When the menses are obstructed, it is not uncommon for the fluor albus to become more abundant, and to be attended with more pain in the back about the menstrual period. If a woman, who has leucorrhœa conceives, the discharge generally stops. In some cases, however, pregnancy produces a discharge of glary fluid, which it has been thought dangerous to check suddenly. Other women are subject to a similar discharge after any fatigue, but get easily rid of it by rest and attention to cleanliness.

The fluor albus is almost always accompanied with a pain in the back and loins, and often with a feeling of weakness. Dyspeptic symptoms, and uneasy sensations, are very generally produced; the countenance is less healthy than formerly, the strength is reduced, and sometimes the patient is fe-

\* Chambon *Malad. des Filles*, p. 104.

verish and emaciated, or has œdematous swelling of the feet. The colour of the discharge is variable, being sometimes white or yellow, without smell, and sometimes dark coloured and offensive. In the mildest form, the discharge is pale or glary, and unaccompanied by symptoms of much local irritation. In a worse degree, the colour is green or yellow, and there is heat about the parts, with pain in the back and uterine region. Foetid discharge is usually connected with a diseased state of the uterus. Should the woman die during the continuance of fluor albus, the uterus is found to have its cavity covered with mucous matter.

Fluor albus may be excited by the presence of a polypus in utero, or in consequence of disease of the womb; but in such cases it is symptomatic, and is not at present to be considered. The idiopathic fluor albus may be produced by various cases, such as abortion, menorrhagia, frequent parturition, excessive venery, cold or fatigue after a miscarriage or a delivery at the full time, and whatever can weaken the action of the uterus. It was at one time supposed, that it might also be produced by a bad state of the fluids of the body, a bilious cacochymy, a leucophlegmatic habit, catarrhal affections, passions of the mind, &c. Worms may produce it.

The vaginal discharge is attended with slighter effects, but the symptoms are similar in kind, with these differences, viz. that menstruation does not make it disappear, and it continues during pregnancy, nay, is even increased, or sometimes brought on by it. Pessaries may have the same effect, and sometimes the prolapsus uteri, for which they are used, causes it.

It is very difficult to distinguish betwixt venereal gonorrhœa, and fluor albus. In the former case, there is at first, at least, evident marks of inflammation, with a heat and smarting in making water, and the discharge has a purulent appearance. In the latter case, although all these symptoms may be present, yet there is much seldomer smarting or

an inflamed state of the parts, and the discharge has more of a mucous appearance. Often, however, we must be determined in our judgment by concomitant circumstances. Topical applications, such as injections of solution of acetate of lead, sulphate of zinc, infusion of oak bark with opium, &c. readily cure the gonorrhœa.

We do not possess any medicine capable of operating directly on the uterus, and improving its action. We must therefore, employ such means as tend to invigorate the whole frame, and thus indirectly improve the action of the organs of generation; at the same time that we obviate an effect of the discharge, namely, weakness, for this may be an effect as well as a cause. When the disease is symptomatic of polypus, cancer, &c. we must attend to its primary cause; but in simple leucorrhœa, we may directly attempt the removal of the discharge, unless it have been of very long standing: in which case, we have been advised to insert an issue\*; but this is perhaps seldom necessary, for the disease does not yield suddenly. Emetics are of very considerable advantage, on account of their operation on the stomach and alimentary canal, and are accordingly advised by most writers †. Purges have also been used ‡, in order to carry off noxious matter; but they are only to be given, so as to keep the bowels regular §, for brisk and repeated purging is hurtful ||. Tonic medicines and those which improve the action of the chylopoetic viscera, such as lime water, myrrh, bark, steel, rhubarb, &c. are also of much utility, and along with them we may, with great advantage, employ the cold bath. The diet is to be light and nourishing, and the patient ought not to indulge in too much sleep. Along with these means we may, with decided advantage, when there is no organic disease, make use of astringent in-

\* Vigarous *Malad. des Femmes*, Tome I. p. 257.

† Smellie, Vol. I. p. 67.—Vigarous, Tome I. p. 261.—Mead, *Med. Precepts*, chap. XIX. sect. 3d.—Denman, Vol. II. page 104.—See also Ettmüller, Riverius, &c. &c.

‡ Chambon *Malad. des Filles*, p. 107.—Mead, *Med. Precepts*, chap. xix. section 3d.

§ Stoll *Praelectiones*, Tomus II. p. 395.

|| Vigarous *Malad. des Femmes*, Tome I. p. 261.



injections, such as solution of alum, sulphate of zinc, &c. changing the ingredients, and varying the strength, till we find some form which is of benefit. These are of great benefit in vaginal discharges, and in the mild form of uterine fluor albus. In every case, the parts ought to be kept clean, by regular ablution.

Various medicines, such as cicuta, uva ursi, balm of gilead, diuretic salts, calomel, resins, cantharides, electricity, arnica, &c. have been proposed; but they have very little good effect, and sometimes do harm. By suckling a child, the discharge has in some instances been removed. Plasters and liniments have been applied to the back, and sometimes relieve the aching pains. Opiates are occasionally required, on account of uneasy sensations. When the discharge seems to be connected with plethora, or attended with a feverish state, bleeding, laxatives, and spare diet are proper.

#### SECTION TWENTY-SECOND.

The bladder is subject to several diseases. The first I shall mention is stone. This excites very considerable pain in the region of the bladder, considerably increased after making water. There is also irritation about the urethra, with a frequent desire to void the urine; but it does not always flow freely, sometimes stopping very unexpectedly. The urine deposits a sandy sediment, and is often mixed with mucus. These symptoms lead to a suspicion that there is a stone in the bladder, but we can be certain only by passing a sound. By means of soda, the warm bath, and opiates, much relief may be obtained, and very often the stone may be passed, for the urethra is short and lax. But when these means fail, an operation must be performed. This has been done during pregnancy\*, but is only allowable in cases of great necessity. Sometimes the stone makes way, by ulceration, into the vagina†. It has even been known to ulcerate through the abdominal integuments‡.

\* Deschamps Traite de l' Oper. de la Taille, Tome IV. p. 9.

† Hildanus, cent. I. obs. 68 and 69.

‡ Vide Case by M. Caumond in Recueil Period.

In many cases the symptoms of stone are met with, although none can be found in the bladder. This is most frequently the case with young girls, previous to the establishment of the catamenia, or with women of an irritable habit. There is no organic disease, nor have I ever known it, in such people, end in a diseased structure of the bladder or kidneys; indeed, they rarely complain of uneasiness about the kidneys. I have tried many remedies, such as soda, uva ursi, narcotics, antispasmodics, tonics, and the warm and cold bath, but cannot promise certain relief from any one of these<sup>53</sup>. In process of time, the disease subsides and disappears. The use of a bougie may be of service.

Induration, or scirrhus of the bladder, produces symptoms somewhat similar to calculus, but there is a greater quantity of morbid mucous mixed with the urine; and blood with purulent matter is discharged, when ulceration has taken place. No stone can be found, but the bladder is felt to be hard and thick. Sometimes it is much enlarged with such appearances, as give rise to an opinion, that the uterus is the part principally affected<sup>54</sup>. The scirrhus and ulceration may extend to the uterus and vagina. In this disease we must avoid all stimulents, and put the patient on mild diet; avoid every thing which can increase the quantity of salts in the urine; keep the bowels open, with an emulsion containing oleum ricini; and allay irritation by means of the tepid bath and opiates. Mercury, cicuta, uva ursi, &c. with applications to the bladder itself, have seldom any good effect, and sometimes do harm.

Polypous tumors<sup>55</sup> may form within the bladder, producing the usual symptoms of irritation of that organ.

In consequence of severe labour, or the pressure of instruments, the neck of the bladder may become gangrenous, and a perforation take place by sloughing. The woman complains of soreness about the parts, and does not void the urine freely. In five or six days the slough comes off, and then the urine dribbles away by the vagina. In all cases of severe labour, and indeed in every case when the urine does not pass freely and at proper intervals, and especially

if there be tenderness of the parts, we must evacuate the water, in order to prevent distention and farther irritation of the bladder ; and the parts must, if there be a tendency to slough or to ulcerate, be kept very clean, and be regularly dressed, in order to prevent improper adhesions. If the bladder should give way, we must try, by keeping in attentively an elastic catheter\*, to make the urine flow by the urethra, and then perhaps the part may heal. If this have been neglected, it will be proper to make the edges of the opening raw by paring if it be large, or by caustic if it be small, and afterwards use the catheter. When an incurable opening is left, we must, by introducing a sponge, or some soft, but pretty large substance, like a pessary, into the vagina, close it up, at least so far as to make the woman more comfortable. In a curious case I met with, there was an attempt by nature, to plug up the opening<sup>56</sup>. Puzos justly remarks, that it is always the bladder, and not the urethra, that suffers.

Sometimes, after a severe labour, the woman is troubled with incontinence of urine, although the bladder be entire. This state is often produced directly by pressure on the neck of the bladder ; sometimes it is preceded by symptoms of inflammation about the pelvis, and, in such cases, the os uteri is often found afterwards to be turned a little out of its proper direction, and the patient complains much of irregular pains about the hypogastrium and back. When the woman is in bed, some of the urine collects in the vagina, and comes from it when she rises ; after she is up, it comes from the urethra alone, which distinguishes this from the complaint last described. Time sometimes cures this disease. The cold bath is useful, unless it increases the pain ; and, in that case, the warm bath should be employed. Benefit is derived from the use of a sponge pessary. It may be proper to use the bougie daily, and also try the effect of tincture of cantharides.

The bladder may descend, in labour, before the uterus, producing much pain ; or it may prolapse for some time pre-

\* This succeeded in a very bad case related by Sedilliot, *Recueil Period.* Tome I. p. 187.



vious to labour, attended with pain resembling those of parturition, and sometimes with convulsive or spasmodic affections<sup>57</sup>. When the prolapsus vesicæ takes place as a temporary occurrence during labour, or antecedent to parturition, we must be careful not to mistake the bladder for the membranes, for thus irreparable mischief has been done to the woman. The bladder when protruded, is felt to be connected with the pubis. It retires when the pain goes off. If the patient be not in labour, the uneasiness is to be mitigated by keeping the bladder empty, and allaying irritation with opiates, and taking a little blood if feverish or restless. If labour be going on, the bladder must likewise be kept empty, and may, during a pain, be gently supported, by pressing on it with a piece of sponge in the vagina, by which the bladder is preserved from injury. In the unimpregnated state, it sometimes descends betwixt the vagina and pelvis, so as to form a tumor within the vagina, or at the vulva. In a case dissected by my brother, the bladder was found to form a hernia on both sides of the pelvis, hanging like a fork over the urethra. This is called a hernia † vesicalis, and is often attended with suppression of urine. If this be inattentively examined, it may be taken for prolapsus uteri; but it will be found to diminish, or even disappear, when the urine is voided, and by pressure, the urine may be forced through the urethra. The hernia vesicalis is to be remedied by the use of a globe pessary or sponge. Sometimes it is combined with calculus in the bladder. In this case, it has been proposed to open the bladder, extract the stone, and keep up a free discharge of urine through the urethra, in order to allow the communication with the vagina to heal. Deschamps advises, that the opening should be made near the pubis, and not at the posterior part of the tumor, lest that part of the bladder be cut, which, when the tumor is reduced, would communicate with the abdominal cavity.

† Vide the *Memoirs and Essays* of Verdier and Sabbatier, and Hoin. Sandifort, *Diss. Anat. Path.* lib. I. cap. iii. and Cooper on *Hernia*, part II. p. 66.

## SECTION TWENTY-THIRD.

Excrescences may, notwithstanding the opinion of Morgagni, form in the course, or about the orifice of the urethra,<sup>56</sup> and generally produce great pain, especially in making water; on which account, the disease has sometimes been mistaken for a calculous affection. The agony is sometimes so great, as to excite convulsions, and it is not uncommon for the patient to have an increase of her sufferings about the menstrual period. When excrescences grow about the orifice of the urethra, they are readily discovered; but when they are high up, it is much more difficult to ascertain their existence. Dr Baillie \* says, they cannot be known, but by the sensation given by the catheter passing over a soft body. They, however, in one case, were discovered, by turning the instrument to one side, so as to open the urethra a little<sup>59</sup>. When their situation will permit, it is best to extirpate them with the knife or scissars; but sometimes they have yielded to the bougie, though they had returned after excision †. The removal of large excrescences, has occasionally been attended with very severe symptoms<sup>40</sup>. The daily use of the bougie, for some time after extirpation, is of service<sup>41</sup>.

Sometimes the urethra is partially, or totally inverted<sup>42</sup>, forming a tumor at the vulva, attended with difficulty and pain in voiding urine. A slight inversion may be relieved by a bougie; when there is a considerable prolapsus, the part must be cut off. The urethra is sometimes contracted by a varicose state of its vessels, or by a stricture; but these are not common occurrences. In continued irritation of the urethra, with difficulty of voiding water, the bougie is often of great service, even although there should be no contraction of the canal itself. Sometimes the urethra is preternaturally dilated<sup>43</sup>, but this does not necessarily cause incontinence of urine.

\* Morbid Anatomy, p. 321.

† Broomfield's Surgery, Vol. II, p. 296.

## SECTION TWEYNT-FOURTH.

The uterus may be larger than usual, or uncommonly small<sup>44</sup>, or it may be altogether wanting<sup>45</sup>. Unless these circumstances be combined with some deficiency, or unusual conformation of the external parts or vagina, the peculiar organization is not known till after death. It is, however, not uncommon for the external parts to be very small, when the uterus is of a diminutive size; and when it is altogether wanting, the vagina is either very short, or no traces of it can be found. In either of these cases, no attempts should be made to discover a uterus by incisions, unless, from symptoms of accumulation of the menses, we are certain that a uterus really exists\*.

The uterus may be double<sup>46</sup>: in this case there is sometimes a double vagina, but generally only one ovarium and tube to each uterus. This conformation does not prevent impregnation.

The uterus is sometimes divided into two, by a septum stretching across at the upper part of the cervix †; or the os uteri is almost, or altogether shut up<sup>47</sup>, by a continuation of the lining of the womb or vagina, or by adhesion, consequent to ulceration, or by original conformation; and in this last case, the substance of the os uteri is sometimes almost cartilaginous. The menses either come away more or less slowly, according to the size of the aperture, or are entirely retained when there is no perforation. As long as the menses are discharged, nothing ought to be done; but if they are completely retained, and violent and unavailing efforts made for their expulsion, an opening must, as a matter of necessity, be made from the vagina. In such cases, the uterus has been tapped with success ‡; but it has also

\* Nabothus mentions a rash operator, who undertook, by incision, to find the uterus; but after cutting a little, he came to some vessels which obliged him to stop.

† Baillie's Morbid Anatomy, chap. xix.

‡ The menses being retained, and great pain excited, they were let out with a trocar by Schutzer. Vide Sandifort, p. 69.



happened, that fatal inflammation has succeeded the operation.

The vessels are sometimes enlarged; and I have seen the spermatic veins extremely varicose, in an old woman who had been subject to piles; but I do not know that any particular inconvenience results from the venous enlargement.

#### SECTION TWENTY-FIFTH.

The uterus is subject to inflammation; but in the unimpregnated state, it is not common for the womb to be the original seat of inflammation. After parturition, it is very frequently inflamed, and this will hereafter be considered. Inflammation is discovered by pain in the hypogastric region, accompanied with tension, and the part is tender to the touch; there is acute pain stretching to the back and groins; the bladder is rendered irritable; and acute fever accompanies these symptoms. Blood letting, purges, fomentations, and blisters are to be used, as in other cases of peritoneal inflammation. Wounds of the uterus are dangerous, in proportion to the inflammation they excite. In the unimpregnated state, this accident is rare \*.

#### SECTION TWENTY-SIXTH.

The uterus may, from irritation, become ulcerated like any other part; purulent matter is discharged, the woman feels pain in coitu, or when the uterus is pressed, and sometimes the finger can discover the ulcer. Simple ulceration is very rare, and, I apprehend, will always heal, by keeping the parts clean with mild injections. Ulceration from morbid poison is more frequent. Of this kind is the phagedena, a most obstinate and dreadful disease of the womb, which begins about its month, and goes on, gradually destroying its substance, until almost the whole of it be removed; and sometimes it spreads to the neighbouring parts. This disease is marked by pain in the region of the uterus, copious

\* In one instance the woman was murdered, by thrusting a piece of glass up the vagina: and Haller notices a fatal case, in which a piece of lead was thrust into the uterus.

foetid discharge, small but frequent pulse, wasting of the flesh, and occasionally swelling of the inguinal glands. Examination, per vaginam, discovers the destruction which has taken place, and how far it has proceeded. It also ascertains, that the part which remains is not enlarged, and in this it differs from a cancerous uterus. The rapidity of the destruction is various in different cases. It is very difficult to cure this ulcer, or even to check its progress. Sometimes mercury has effected a cure, either by itself, or combined with cicuta; or hyocyamus, or other narcotics, have been given alone. Nitrous acid occasionally gives relief, and, when greatly diluted, forms a very proper injection. A very weak solution of nitrate of silver, or oxymuriate of mercury, is also a good topical application. Should the pain be great, tepid decoction of poppies, or water with the addition of tincture of opium, will be of service as an injection. Fomentations to the lower belly, and friction with camphorated spirits on the back, also give relief; but very frequently opium, taken internally, affords the most certain mitigation of suffering.

There is another kind of ulcer, which attacks the cervix and os uteri. It is hollow, glossy, and smooth, with hard margins; and the cervix, a little beyond it, is indurated, and somewhat enlarged, but the rest of the uterus is healthy. The discharge is serous, or sometimes purulent. The pain is pretty constant, but not acute; and the progress is generally slow, though it ultimately proves fatal, by hectic. In this, and all other diseases of the uterus, the morbid irritation generally excites leucorrhœa, in a greater or less degree; but examination ascertains the morbid condition of the part. Although this disease be very different in its nature from the former, yet the mode of treatment is very much the same. Material benefit may be derived from the warm salt-water bath, and the regular use of a solution of some saline purgative, or a laxative mineral water, such as that of Harrogate or of Cheltenham. This is especially the case, when the ulcer is small, or when the part is only indurated, ulceration not having yet taken place. In this stage, the cervix

is felt hard and sensible to the touch, and there is leucorrhœa, and pain in the uterine region. A gentle mercurial course is occasionally of service. Some may consider this disease as a species of cancer, but the ulcer is never fungous.

Venereal ulceration may, although the external parts be sound, attack the uterus, producing a sense of heat with pain, which, in general, is not very great, and is not constant. There is sometimes, at first, very little discharge; but if the disease be allowed to continue, foetid purulent matter comes away. The ulcer is at first small, and there is no hardness about the os uteri, nor is it perceived to be dilated; but it is painful to the touch, and sometimes bleeds after coition. In process of time, the ulcer spreads, and may destroy a great part of the womb and bladder, and occasion fatal hectic. The history of the patient may assist the diagnosis. The cure consists in a course of mercury \*.

#### SECTION TWENTY-SEVENTH.

Scirro-cancer may attack any part of the uterus, but generally begins in the cervix. It may take place in the prime of life, but is most frequent about the time of the cessation of the menses. It begins with a feeling of heaviness or heat, and darting pains about the hypogastrium, aching in the back, dull pain about the upper and inner part of the thighs, with a sense of bearing down, together with dysuria, and glowing heat, or sometimes stinging pain betwixt the pubis and sacrum, with itehiness of the vulva. There is a leucorrhœal discharge from the vagina, or uterus, or from both. The patient is troubled with flatulence, and sometimes with vomiting. The general health suffers, the countenance becomes sallow, the pulse quickens, the strength declines, and the body wastes. If the menses have not entirely ceased, they become irregular, or profuse. Presently a foetid, purulent, or bloody matter is discharged, which indicates that an abscess has burst, and the disease has proceeded to ulceration. Repeated hemorrhages are now apt to take place, and

\* Vide Med. Comment: Vol. XIX. p. 257.—Pearson on Cancer, p. 119.



hectic is established. The pain is constant, but subject to frequent aggravations, and the weakness rapidly increases. At length the pain, fever, want of rest, discharge, and loss of blood, completely exhaust the patient; and death terminates, at once, both her hopes and sufferings.

At first, by examination per vaginam, the uterus is felt as if it were enlarged; the cervix is lengthened and thickened, and the os uteri open, and more sensible to the touch, a circumstance which causes pain in coitu. A little blood is often observed on the finger after an examination. In some time after this, the os uteri is turgid, as if it contained a small abscess, and presently it is felt to be ulcerated and fungous; but sometimes the fungi are less perceptible, deep excavations being formed, the sides of which, however, after death, are found to be fungous.

The uterus is sometimes very much enlarged before ulceration takes place; but, in other cases, the augmentation is much greater after ulceration, than before it; or the morbid affection may be very much confined to the cervix uteri<sup>48</sup>. In some cases, the womb acquires a size greater than the head of a child; in others, it is not above double its usual magnitude, or I have seen a scirrhus tumour form in the uterus, and enlarge alone, whilst the rest of the uterus was nearly natural. In this case, the tumor may perhaps be felt behind, or to one side, like an enlarged ovarium. In some, the disease proves fatal very early; in others, great devastation takes place, and the bladder<sup>49</sup> or rectum\* is opened. In most cases, the vagina becomes hard and thickened; or irregularly contracted with swelled glands, in its course.

On examining the uterus after death, its substance is found to be thickened and indurated, and sometimes its cavity is enlarged. The substance is of a whitish or brownish colour, intersected with firm membranous divisions; and betwixt these are numerous cysts, the coats of which are thick and white. They contain a vascular substance, which, when

\* M. Tenon found, in a case of cancerous uterus, all the posterior part of the womb ulcerated, the rectum diseased, and a communication formed betwixt them.

wiped clean, is of a light olive colour. In proportion as the disease advances, some of the cysts enlarge, and thicken still more; and, when opened, are found to contain a bloody lymph, and to have the inner surface covered with a spongy vascular substance, similar to that which fills the small cysts, but rather more resembling fungus. Presently some of these cysts augment so much as to resemble abscesses, though they are not properly speaking abscesses, and soon afterwards they burst.

It is extremely rare for a cyst to burst, or fungi to shoot out on the exterior surface of the uterus, which is covered with the peritoneum; but sometimes all the cavity of the womb is lined with irregular fungi, or very vascular substance. Occasionally the tubes \* and ovaria participate in the disease. The position of the uterus is often natural, but sometimes it is inclined to one or other side, or approaches to a state of retroversion.

This is a very hopeless disease, but still much may be done to check its progress, or mitigate its symptoms. When uneasy sensations, about the cessation of the menses, indicate a tendency to uterine disease, we find advantage from the insertion of an issue in the arm or leg, the use of laxative waters †, and spare diet<sup>50</sup>. If by examination we discover any alteration in the shape, size, or sensibility of the womb, the most effectual treatment we can have recourse to, is the daily use of from two to three drachms of sulphas potassæ cum sulphure; and if this lose its laxative effect, one or more alloetic pills may be added. The warm sea water bath every night is likewise of great service. When there is much sense of throbbing, heat, or pain about the pelvis, cupping glasses applied to the back or hypogastrium are occasionally of service, and the patient should keep in a horizontal posture as much as possible. When the disease has evidently taken place, we must still persevere in the same plan, and avoid such causes

\* Vide Prochaska Annō. Acad. fasc. 2d.

† Roderer relates a case where scirrhus swelling was cured by keeping the bowels open, and giving every third evening, from ten to twenty grains of calomel.—Haller Disp. Med. Tomus IV. p. 670.

as excite action in general; keep the parts clean, by injecting tepid water, or decoction of camomile with hemlock or opium; allay pain by anodynes; and attend to the state of the bowels. Mercury, sarsaparilla, aconitum, cicuta, &c. have been given internally, but have seldom a good effect. It has been proposed to produce, with an extracting instrument, a prolapsus uteri, and then cut off the protruded womb; but this operation is not likely to be resorted to.

#### SECTION TWENTY-EIGHTH.

Tubercles are common in the uterus, insomuch that M. Bayle says, that in seven months he met with fourteen cases. They consist at first of fleshy matter, but in process of time become more like cartilage, or even bony, especially on their surface\*. On examining the tumor, it is found to be intersected with membranous divisions; and a section exhibits a pretty compact granulated surface. A tubercle may take place in one spot, and all the rest of the uterus may be healthy, and nearly of the natural size. The magnitude of the tubercle is very variable, and it may either project on the outer surface, or within the cavity of the womb; and in this last case, the adhesion to the surface of the cavity is generally slight † after the tubercle has fully projected. In this it differs, even in its most detached state, from polypus, which is attached not by cellular substance, but by a pedicle. Sometimes there are a great many tubercles, which are found in various stages of projection, and the uterus may become greatly enlarged, and very irregular externally ‡. I have never seen the tubercle end in ulceration, nor the substance of the uterus, although thickened, have abscess formed in it. The effects of this disease are a pain in the back, and sometimes in the hypogastrium, which is swelled if there be much enlargement of the womb, dyspeptic symptoms, leucorrhœa,

\* Sandifort Obs. Anat. Path. lib. I. cap. viii.—Bayle in Jour. de Med. Tome V.—Murray de Osteotomate, p. 11, et seq.

† Baillie's Morbid Anatomy, chap. xix.

‡ I have found the uterus as large as a child's head of a year old, with many projections and tubercles.—Peyer has a similar case, Parerg. Anat. p. 131.



and at length feverishness and gradual loss of strength. The progress is generally slow, and the pain and other symptoms less acute than in cancerous uterus. Sometimes one or more tubercles are thrown off, with pains like those of labour.

The antiphlogistic regimen should be pursued in moderation. The bowels especially should be kept open, and every source of irritation removed. The general treatment proposed in cancer, is in every respect proper, and is still more effectual than in that disease. Women may live a long time, even although these tumors acquire considerable magnitude.

Sometimes the whole uterus is a little enlarged, and changed into a white cartilaginous substance, with a hard irregular surface; or it may be enlarged and ossified<sup>51</sup>, and these ossifications may take place even during pregnancy\*. Steatomatous or atheromatous tumors of various sizes †, or sarcomatous ‡ or scirrhus-like || bodies, may be attached to the uterus. All these diseases sometimes at first give little trouble. Even their advanced stage has no pathognomonic mark, by which they can be discovered, as they produce the usual effects of uterine irritation. I must also add, that they are very little under the power of medicine. The most we can do, is to palliate symptoms; by which, however, we greatly meliorate the condition of the patient.

#### SECTION TWENTY-NINTH.

The uterus is more frequently affected with spongoid tumor than is supposed; many cases of that disease passing for cancer. This is a firm, but soft and elastic tumor, the substance of which bears some resemblance to brain, and contains cysts of different sizes, filled with red serum or blood, or bloody fungus according to circumstances. There is no certain way of distinguishing or discovering this disease in

\* Vide *Observ. on Abortion*, 2d edition, p. 37.

† Vide Rhodius, cent. III. ob. 46.—Behmer *Obs. Anat. fac.* 2d.—Stoll *Ratio Med.* part II. p. 379.

‡ Vide Friedius, in Sandifort's *Observ.* lib. I. c. viii. and a case by Sandifort himself, where the tumor adhered by a cord, lib. IV. p. 113.

|| Baader *Obs. Med.* ob. 29. p. 170.

its early stage, for it often gives very little trouble, and any symptoms which do occur, are common to other diseases of the womb. The tumor, however, enlarges, and can at length be felt through the abdominal parietes. It is soft and elastic, and on the first application of the hand, feels very like a tense ventral hernia. There may be two or more tumors of unequal sizes in different parts of the belly, which can be felt to have a connection with each other, and may frequently be traced to the pubes. *Per vaginam*, the state varies in different cases; but by pressing on the external tumor at the same time, we discover its connection with the womb below. We may find ulceration, or the os uteri soft, and tumified, and opened, or the posterior lip may be lost in a soft elastic tumor, and quite obliterated, whilst the anterior one, after a pretty careful examination, is felt high up, and apparently sound. Pressure seldom gives pain, till ulceration is about to take place, and no blood is usually observed on the finger after examination, unless a fungus has protruded. So far as I have seen, fluor albus is a rare attendant on this disease in the early stage, and little inconvenience is at that period produced, except what results from pressure on the bladder, causing strangury or suppression of urine, attended with fits of considerable pain, like those excited by a stone. The complexion is yellow, but the health is tolerably good, till ulceration or inflammation take place. This event may happen in different ways, it may be directed to the vagina, and then we have fœtid bloody discharge, or sometimes considerable hemorrhage, and ultimately the bladder or rectum are involved in the destruction: Or bloody fungus may protrude from the exterior surface of the uterus into the general cavity of the abdomen, and at length the bowels become inflamed and glued together: Or the tumor may adhere to the parietes of the abdomen, and the skin after becoming livid gives way, and a fungus shoot out from the belly. As the disease advances towards ulceration, the health is more impaired, hectic fever takes place, and the patient is ultimately cut off.

The whole treatment, I am sorry to say, consists in pal-

liating such sympathetic or local symptoms as may arise in the course of the disease.

#### SECTION THIRTIETH.

Earthly concretions are sometimes formed in the cavity of the uterus, and produce the usual symptoms of uterine irritation; and Vigarous considers them as very apt to excite hysterical affections. As in the bladder of urine, the constant presence of a calculus tends to thicken its coats; so the irritation of a stone in the uterus can excite a disease of the substance of the womb, and produce ulceration, which may extend to the rectum. The disease in question is very rare, and can only be discovered by feeling the concretion with the finger, or a probe introduced within the os uteri, which is sufficiently open to permit of this examination. Nature, it would appear, tends to expel the substance<sup>52</sup>; and we ought to co-operate, if necessary, with this tendency. We must also relieve suppression of urine\*, or any other urgent symptom which may be present.

#### SECTION THIRTY-FIRST.

Polypous tumours are not uncommon, and may take place at any age; they are not, however, often met with in very young women. They always affect the health, producing want of appetite, dyspeptic symptoms, uneasiness in the uterine region, a variable swelling of the abdomen, aching pain in the back, bearing down pains, tenesmus, and a dragging sensation at the groins. When these symptoms have continued some time, the strength is impaired, and the pulse becomes more frequent. At first, there is generally a foetid discharge like leucorrhœa; but at length blood is discharged, owing to the rupture of some of the veins of the tumor, or sometimes from the uterine vessels themselves. These symptoms, however, cannot point out, to a certainty, the existence of a polypus: we must have recourse to examination, by which we discover that the uterus is enlarged, its

\* This proved fatal in a child of five years old.



mouth open, and a firm, but generally moveable body within it. If the os uteri have not yet opened, so as to admit the finger, the diagnosis must be incomplete.

By degrees the polypus descends from the uterus, or painful efforts are made more quickly to expel the tumor; the body of which passes into the vagina<sup>53</sup>; and sometimes occasions retention of urine<sup>54</sup>. The pedicle remains in utero, and the bad consequences formerly produced still continue, except in a few cases, where the tumor has dropped off\*, and the patient got well. In such cases, it has been supposed that the os uteri acted as a ligature; and to the same cause is attributed the bursting of the veins, which produce, in many instances, copious hemorrhage. But although hemorrhage be most frequent after the polypus has descended, yet it may take place whilst it remains entirely in utero.

It sometimes happens that the uterus becomes partially inverted†, before or after the polypus is expelled into the vagina; and this circumstance does not seem to depend altogether on the size of the polypus, or its weight. Polypus may also be accompanied with prolapsus uteri‡.

Polypi may be attached to any part of the womb, to its fundus, cervix, or mouth; and it has been observed, that there is less tendency to hemorrhage, when they are attached to the cervix, than either higher up, or to the os uteri itself. If there be an union betwixt the os uteri and the tumor||, or if they be in intimate contact, polypus may pass for inversio uteri; but the history of the case, and attentive examination, will point out the difference, which will be noticed when I come to consider inversion and prolapsus of the uterus. Here I may only remark, that the womb is sensible, but the polypus is insensible to the touch, or to irritation; but it should be recollected, that if the polypus be moved, sensation can be produced by the effect on the womb.

\* Mem. de l'Acad. de Clér. Tom. III. p. 552.

† Vide case by Goussard, in Hist. de l'Acad. de Sciences, 1732, p. 42.—Dr Denman, in his *engravings*, gives two plates of inversion, one from Dr Hunter's Museum, the other from Mr Hamilton.

‡ Med. Comment. Vol. IV. p. 229.

|| Mem. of Med. Society in London, Vol. V. p. 12.

Polypi are of different kinds. The most frequent kind is of a firm semicartilaginous structure, covered with a production of the inner membrane of the womb; and indeed it seems to proceed chiefly from a morbid change of that membrane, and a slow subsequent enlargement of the diseased portion; for the substance of the uterus itself is not necessarily affected. The enlargement is generally greatest at the farthest extremity of the tumor, and least near the womb; so that there is a kind of pedicle formed, which sometimes contains pretty large blood vessels, and the tumor is pyri-form. But if the membrane of the uterus be affected to a considerable extent, and especially if the substance of the uterus be diseased, then the base, or the attachment of the polypus, is broad.

The vessels are considerable, especially the veins, which sometimes burst. In every instance, I believe, if the patient live long, the tumor is disposed to ulcerate. The ulcer is either superficial and watery, or it is hollowed out, glossy, and has hard margins, or it is fungous. The two last varieties are most frequent.

Some polypi are soft and lymphatic, but these are rare in the uterus. Some are firm without, but contain gelatinous fluid, or substance like axunge within. Some are solid, others cellular, with considerable cavities.

Polypi are hurtful at first, by the irritation they give the uterus, and by sympathetic derangement of the abdominal viscera. In a more advanced stage, they are attended with debilitating and fatal hemorrhage, and often with febrile symptoms, especially if the discharge be offensive, or the surface ulcerated. Notwithstanding the existence of polypus, however, it is possible for a woman to conceive\*.

Various means have been proposed for the removal of polypi, such as excision, caustic, or tearing them away; but all of these are dangerous and uncertain; and therefore the only method now practised, is to pass a ligature round the base or footstalk of the polypus, and tighten it so firmly as

\* In M. Guiot's case, the polypus was expelled.—M. Levret adds other cases, *Mém. de l'Acad. de Chir. Tom. III. p. 543.*

to kill the part. The ligature consists of a firm silk cord, or a well twisted hemp string, properly rubbed with wax, or covered with a varnish of elastic gum. This is better than a silver wire, which is apt to twist or form little spiral turns, which impede the operation, and may cut the tumor. It is difficult to pass the ligature properly, if the polypus be altogether in utero; and it ought not even to be attempted, if the os uteri be not fully dilated. On this account, if the symptoms be not extremely urgent, it is proper to delay until the polypus have wholly, or in part, descended into the vagina; and when this has taken place, no good, but much evil may result from procrastination. It has even been proposed to accelerate the descent of the polypus, and produce an inversion of the uterus\*.

A double canula has been long employed for the purpose of passing the ligature, one end of which was brought through each tube; and the middle portion, forming a loop, was carried over the tumor, either with the fingers, or the assistance of a silver probe with a small fork at the extremity. By practice and dexterity, this instrument will doubtless be adequate to the object in view; but without these requisites, the operator will be foiled, the ligature twisting or going past the tumor, every attempt giving much uneasiness to the patient, and not unfrequently, after many trials and much irritation, the patient is left exhausted with fatigue, vexation, and loss of blood. This is very apt to happen, if the polypus be so large as to fill the vagina. The process may be facilitated by employing a double canula, but the tubes made to separate and unite at pleasure†, by means of a connecting base, or third piece, which can be adapted to them like a sheath. The ligature is to be passed through the tubes, which are to be placed close together, and no loop is to be left at the middle. They are then to be carried up along the tumor, generally

\* M. Baudelocque observes, " Nous regardions ce renversement necessaire pour obtenir la guerison de la malade." *Recueil Period.* Tome IV. p. 137.

† An instrument of this kind is proposed by M. Cullerier, and is described by M. Lefaucheux in his *Dissert. sur les Tumeurs Circonscrites et Indolentes du tissu cellulaire de la matrice et du vagin.*



betwixt it and the pubis. Being slid up along the finger to the neck of the polypus, one of them is to be firmly retained in its situation by an assistant, and the other carried completely round the tumor, and brought again to meet its fellow. The two tubes are then to be united by means of the common base. The ligature is thus made to encircle the polypus, and, if necessary, it may afterwards be raised higher up with the finger alone, or with the assistance of a forked probe.

When the ligature is placed in its proper situation, it is to be gradually and cautiously tightened, lest any part of the uterus which may be inverted be included. If so, the patient complains of pain, and sometimes vomits; and if these symptoms were neglected, and the ligature kept tight, pain and tension of the hypogastrium, fever and convulsions would take place, and in all probability the woman would die<sup>55</sup>. In some instances, however, the womb has been included without a fatal effect<sup>56</sup>.

Even when the uterus is not included, fever may succeed the operation, and be accompanied with slight pain in the belly; but the symptoms are mild, and no pain is felt when the ligature is first applied.

If the first tightening of the ligature, by way of trial, give no pain, it is to be drawn firmly, so as to compress the neck of the tumor sufficiently to stop the circulation. It is then to be secured at the extremity of the canula; and as the part will become less in some time, or may not have been very tightly acted on at first, the ligature is to be daily drawn tighter, and in a few days will make its way through. After the polypus is tied, it is felt to be more turgid, and harder; and if visible, it is found of a livid colour, and presently exhales a foetid smell. These are favourable signs.

#### SECTION THIRTY-SECOND.

There are other tumors still more dangerous\*, as they end in incurable ulceration, and are so connected with the womb,

\* Vide Mem. de l'Acad. de Chir. Tome III. p. 588.—Holiniaux Observations, Tome I. ob. 39.—Baillie's Mercur. Anatomy, chap. xix.—Vigourous de Malad. des Femmes, Tome I. p. 425.

that the whole of the diseased substance cannot be removed. These always adhere by a very broad base<sup>57</sup>, and cannot be moved freely, or turned round like the mild polypus. They are sometimes pretty firm, but generally they are soft and fungous, or may resemble a mass of clotted blood. When dissected, they are found to be very spongy, with cells or cavities of various sizes; sometimes they are laminated. These, which have been called vivacæ by M. Levret, are always the consequence of a diseased state of the womb; but they are not always, as that author supposes, vegetations from an ulcerated surface. They do, however, very frequently spring from that source, being generally of the spongoid nature. Occasionally they have been mistaken for a piece of a retained placenta, and portions of fœtid fungi have been torn away, in attempts to extract the supposed placenta, or ovum.

The hypogastric region is tumid, and painful to the touch, even more so than the tumor itself, which, felt per vaginam, is less sensible than the womb. Sometimes little pain is felt in this disease, except when the womb is pressed. The tumor often bleeds, discharges a sanious matter, and may shoot into the vagina; but in this it differs from polypus, that it comes into the vagina generally by growth, and not by expulsion from the womb, which does not decrease or become empty as the vagina fills. The treatment must be palliative, for extirpation does not succeed, the growth being rapidly renewed. Opiates and cleanliness are most useful.

#### SECTION THIRTY-THIRD.

Moles\* are fleshy or bloody substances contained within the cavity of the uterus. They acquire different degrees of magnitude, and are found of various density and structure<sup>58</sup>. They may form in women who have not born children†, or they may succeed a natural delivery‡, or follow an abortion,

\* Sandifort Obs. Path. Anat. lib. II. p. 78.—Schmid. de Concrement. Uteri, in Haller's Disp. Med. Tomus IV. p. 746.

† La Motte, chap. vii. This chapter contains several useful cases, one of which proved fatal from hemorrhage.

‡ Hoffman, Opera, Tomus III. p. 182.—Stahl. Coleg. Casuale, cap. lxxvi. p. 797.

or take place in a diseased state of the uterus\*. It is the opinion of many, that these substances are never formed in the virgin state, and no case that I have yet met with contradicts the supposition. The symptoms produced by moles are at first very much the same with those of pregnancy, such as nausea, fastidious appetite, enlargement of the breasts, &c.; but the belly enlarges much faster, is softer, and more variable in size than in pregnancy, being sometimes as large in the second month of the supposed, as it is in the fifth of the true pregnancy. Pressure occasionally gives pain. Petit observes, that the tumor seems to fall down when the woman stands erect, but this is not always the case. It must be confessed, that the symptoms are at first, in most cases, ambiguous, nor can we for some time arrive at certainty. In general, the mass is expelled within three months, or before the usual time of quickening in pregnancy; and more or less hemorrhage accompanies the process, which is very similar to that of abortion, and requires the same management†. Sometimes the expulsion may be advantageously hastened, by extracting the tumor with the finger; but we must be careful not to lacerate it, and leave part behind. If the mole be retained beyond the usual time of quickening, we find that the belly does not increase in the same proportion as formerly, and the womb does not acquire the magnitude it possesses in a pregnancy of so many months standing. There is also no motion perceived. Many of the symptoms of mole may proceed from polypus; but in that case, the breasts are flaccid, and the symptoms indicating pregnancy are much more obscure. The os uteri is not necessarily closed in a case of polypus; whereas in that of a mole, if there have been no expulsive pains, it is generally shut.

When a woman is subject to the repeated formation of moles, I know of no other preventive, than such means as improve and invigorate the constitution in general, and the uterus in consequence thereof. This is of no small impor-

\* With scirrhus of the uterus, Haller's *Disp. Med.* IV. p. 751 et 753.

† Puzos advises blood letting. *Traite*, p. 211.—Vigorous recommends emetics and purgatives, to favour the expulsion, *Tome 1.* p. 115.



tance as a weak state of the uterine system predisposes to more formidable diseases, and may be followed by scirrhus of the womb or of the breast.

#### SECTION THIRTY-FOURTH.

Hydatids may also enlarge the womb, and these frequently are formed in consequence of the destruction of the ovum at an early period<sup>59</sup>, or of the retention of some part of the placenta, after delivery or abortion. We possess no certain diagnostic; when they are formed in consequence of coagula, or part of the placenta remaining in utero, the symptoms must be such as proceed from the bulk of the womb, or from its irritation, as if by a polypus or mole. The remarks in the preceding section are therefore applicable here; but in a great majority of cases, hydatids are formed, consequent to the destruction of the ovum; and accordingly, the symptoms at first are exactly the same with those of pregnancy. Presently these cease, and we have the time when the ovum is blighted, marked by the breasts becoming flaccid, and the sickness and the sympathetic effects of pregnancy going off. The conception remains, and the belly either continues nearly of the same size, or, if it increase, it is very slowly. Menstruation does not take place; but there may occasionally be discharges of blood in different degrees. No motion is perceived by the woman, and the size of the belly and state of the womb do not correspond to the supposed period of pregnancy. In some instances, the health does not suffer; in others, feverishness and irritation are produced. After an uncertain lapse of time, pains come on, and the mass is discharged, often with very considerable hemorrhage. The process may often be advantageously assisted by introducing the hand to remove the hydatids, or to excite the contraction of the womb; but this must be done cautiously, and only when hemorrhage or some other urgent symptoms occur. These must be treated on general principles.

In some cases, milk is secreted after the hydatids are expelled. In others, a smart fever, with pain in the hypogastrium, follows. It requires laxatives and fomentations.

When hydatids form in a blighted ovum, their number varies greatly in different cases. In some I have seen only a little bit containing vesicles, often only the under part which had been for some time detached in a threatened abortion. In others, almost the whole is changed, and the mass much enlarged. This, I presume, is connected with the womb, by the unchanged portions alone; and therefore, in examining the inner surface of such a uterus after the mass was expelled, we should expect to find it more or less similar to the gravid state, according to the greater or less change in the ovum. The relative magnitude of the vessels in the two states has not been ascertained, few opportunities being afforded of dissection in this disease.

Sometimes there is only one large hydatid, or, at most, a very few in the womb, and the preceding remarks will also be applicable, in a great measure, to this case. In the advanced stage, we find the belly swelled, as in pregnancy; but the breasts are flaccid, and no child can be discovered in utero, nor does the woman perceive any motion. There may be pain in the abdomen, and obscure fluctuation is discernible. The neck of the womb is small, and the case much resembles ovarian dropsy, except that the tumor occupies the region of the uterus. The duration of this complaint is uncertain; but the water is at last discharged suddenly, and after making some exertion. The bag afterwards comes away, and the process is not attended with much pain\*. It is most prudent to be patient; but if the symptoms be troublesome, the fluid can be drawn off by the os uteri. This disease, a solitary hydatid, is oftener combined with pregnancy, or with a mole, than met with alone. The first combination<sup>60</sup> is not uncommon, and I have seen the hydatid expelled some weeks before labour. Hildanus gives an instance of the second, where the ovum was converted into a mole intimately connected to the uterus, and complicated with a collection of fluid to the extent of six pounds. In this case, so much irritation was given, as to exhaust the strength, and produce local inflammation.

\* Hildanus, I think, relates the history of a woman who was supposed to be pregnant, but, *dum noctu cum marito rem haberet*, a sudden inundation swept away her hopes.

## SECTION THIRTY-FIFTH.

A different disease from that described in the last section, is an increased secretion from the uterus itself, accompanied generally with symptoms of uterine irritation; and if the woman menstruate, the menses are pale and watery. There may be a constant stillicidium of water\*, or from some obstructing cause the fluid may be for a time retained,<sup>61</sup> and repeatedly discharged in gushes; or it may be accumulated in great quantity, and combined with a diseased state of the uterus.† Like other irritations of the uterus, this may be accompanied with a secretion of milky fluid in the breasts, or the secretion may be watery. I do not know any thing more likely to do good, than evacuating the serum by the os uteri, and injecting some astringent liquid daily, at the same time that we use means for improving the general health, or removing any particular symptom that may occur.

## SECTION THIRTY-SIXTH.

Worms‡ have been found in the uterus, producing considerable irritation; and generally, in this case, there is a foetid discharge. We can know this disease only by seeing the worms come away. It is cured by injecting strong bitter infusions.

## SECTION THIRTY-SEVENTH.

Sometimes || air is secreted by the uterine vessels, and comes away involuntarily, but not always quietly. Tonics, and astringent injections, occasionally do good; and as this disease rarely causes sterility, it is sometimes cured permanently by pregnancy. It is said, that the air is, in certain

\* Hoffman mentions a woman who had a constant stillicidium, a pint being discharged daily. It at last proved fatal. Opera, Tom. III. p. 160.

† Vesallus, Tom. I. p. 438, says, that he found an uterus containing 180 pints of fluid, and its sides in many places scirrhus.

‡ Vigarous Malad. Tome I. p. 412.—Mr Cockson mentions a case, where maggots were discharged before the menstrual fluid. The woman was cured, by injecting oil, and infusion of camomile flowers. Med. Comment. Vol. III. p. 86.

|| Vide Vigarous' Maladies, Tome I. p. 401.



cases, retained, and the uterus distended with it, producing a tympanitis of the uterus.

#### SECTION THIRTY-EIGHTH.

The prolapsus, or descent of the uterus, takes place in various degrees\*. The slightest degree, or first stage, has been called a relaxation; a greater degree, a prolapsus; and the protrusion from the external parts, a procidentia. It is necessary to attend carefully to this disease, to ascertain its existence, as it may, if neglected, occasion bad health, and many uneasy sensations. The symptoms at first, if it do not succeed parturition, are ambiguous, as some of them may proceed from other causes. They are principally pain in the back and about the pubis, increased by walking, and generally accompanied with a sensation of bearing down. In a more advanced state, the urine is obstructed, and the patient feels a tumor or fulness toward the orifice of the vagina. There are also, during the whole course of the complaint, but especially after it has continued for some time, added many symptoms, proceeding from derangement of the action of the stomach and bowels, together with a variety of those called nervous. On this account, an inattentive practitioner may obstinately consider the case as altogether hysterical, until emaciation and great debility are induced.

But if the woman have been recently delivered, there is less likelihood of the practitioner being misled. She feels a weight and uneasiness about the pubis and hypogastric region, with an irritation about the urethra and bladder; and sometimes a tenderness in the course of the urethra, or about the vulva. A dull dragging pain is felt at the groins, and when she stands or walks, she says she feels exactly as she did before the child was born, or as if there were something full and pressing. Pains are felt in the thighs, and the back is generally either hot, or aches. These symptoms go off in a great measure, when she lies down, though, in some cases, they are

\* Vide Memoir by Sabatier, in the 3d Vol. of the Memoirs of the Academy of Surgery.

at first so troublesome, as to prevent rest. In some instances; no pain is felt in the back; but whenever the patient stands, she complains of a painful bearing-down sensation, or sometimes of pressure about the urethra; or orifice of the vagina.

By examination, the uterus is felt to be lower down than usual, and the vagina either corrugated or inverted. In certain circumstances, the vagina prolapsés, forming a circular protrusion at the vulva, similar to prolapsus ani. In the greatest degree, or procidentia, the uterus is forced altogether out, inverting completely the vagina, and forming a large tumor betwixt the thighs. The intestines descend<sup>62</sup> lower into the pelvis, and even may form part of the tumor, being lodged in the inverted vagina, giving it an elastic feel. The uterus is partially retroverted, for the fundus projects immediately under the perinæum; and the os uteri is directed to the anterior part of the tumor. The orifice of the urethra is sometimes hid by the tumor, and the direction of the canal is changed; for the bladder, if it be not scirrhus, or distended with a calculus of large size, is carried down into the protruded parts;<sup>63</sup> and a catheter passed into it, must be directed downwards and backwards. The procidentia is attended with the usual symptoms of prolapsus uteri, and also with difficulty in voiding the urine, tenesmus, and pain in the tumor. If it be long or frequently down, the skin of the vagina becomes hard, like the common integuments. Sometimes the tumor inflames, indurates, and then ulceration or sloughing takes place. This procidentia may occur in consequence of neglecting the first stage, and the uterus is propelled with bearing down pains; or it may take place all at once, in consequence of exertion, or of getting up too soon after delivery. It may also occur during pregnancy, and even during parturition. Sometimes it is complicated with stone in the bladder,<sup>64</sup> or with polypus in the uterus\*.

Some have, from theory, denied the existence of prolapsus,<sup>65</sup> and others have disputed whether the ligaments were

\* Vide the case of a girl aged twenty-one years, related by Mr Fynney. The polypous excrescence was extirpated from the os uteri, and then a pessary was employed. *Med. Comment.* Vol. IV. p. 228.

torn or relaxed. There can be little doubt, that when it occurs speedily after delivery, it is owing to the weight of the womb, and the relaxed state of the ligaments and vagina. From these causes, getting up too soon into an erect posture, or walking, may occasion prolapsus, particularly in those who are weak or phthisical. When it occurs gradually in the unimpregnated state, it is rather owing to a relaxation of the vagina, and parts in the pelvis, than elongation of the round ligaments. By experiments made on the dead subject, we find, that more resistance is afforded to the protrusion, by the connection of the uterus and vagina to the neighbouring parts, than by the agency of the ligaments; for although the ligaments be cut, we cannot, without much force, make the uterus protrude. Frequent parturition, fluor albus, and whatever tends to weaken or relax the parts, may occasion prolapsus. Sometimes a fall brings it on. No age is exempt from it.<sup>66</sup> When symptoms indicating prolapsus uteri manifest themselves, we ought to examine the state of the womb, the patient being in an erect posture. The symptoms sometimes at first turn the attention rather to the bladder or pubis, than the womb; but a practitioner of experience will think it incumbent on him to ascertain the real situation of the viscus. If it be found considerably lower down than it ought to be, or the vagina lax and tumid from partial inversion, then we must have recourse to mechanical means for keeping it up. A piece of sponge introduced into the vagina, will have this effect, or we may use a pessary. The sponge ought to be oblong, and so large as to support the womb, but not to give uneasiness. It must be freed from earthy matter, and is to be softened and compressed, and then cautiously introduced, having previously had a firm tape passed through it, that it may be more conveniently withdrawn. Imprudent and rude attempts give pain, and may excite swelling and inflammation of the parts. The sponge gives immediate relief to the feeling produced by standing or walking, but it does not altogether remove them for some time. It is prudent to lie almost constantly for several days afterwards, on a sofa, and even



for some weeks to be much in a horizontal posture. I need scarcely add, that the size and shape of the sponge may require alteration.

Pessaries are made of wood, and are of different shapes, some oval, some flat and circular, some like spindles, or the figure of eight, others globular. I believe, of all these, the globular pessary is the best, and it ought to be of such size as to require a little force to introduce it into the vagina; that is to say, it must be so large as not to fall through the orifice, when the woman moves or walks. A bag of elastic gum stuffed with hair, often makes a convenient pessary. Whatever be employed, it ought to be taken out every night, and cleaned.<sup>67</sup> By diminishing gradually the size of the pessary, we may often be able at last to dispense with it. In all the stages, a firm broad bandage applied round the abdomen, frequently relieves the uneasy sensation about the back and pubis. Astringent injections may be thrown into the vagina morning and evening with much advantage, and ought always to be employed. The cold bath is also useful. It is farther necessary to mention, that the symptoms and treatment of prolapsus may be modified by circumstances which precede it, but with which, it is not essentially connected. For instance, a tender or inflamed state of the uterus, and the appendages may take place after delivery, and when convalescent, the patient may rise too soon, or sit up, striving to make the child suck, and thus bring on a degree of prolapsus. In this case, it is evident that the symptoms may be more acute or painful, and they will not be removed by a pessary, until by continued rest, laxatives, and occasional fomentations, the morbid sensibility of the parts within the pelvis be got rid of.

If a procidentia be large, and have been of long duration, the reduction of the uterus may disorder the contents of the abdomen, producing both pain and sickness. In this case, we must enjoin strict rest in a horizontal posture. The belly should be fomented, and an anodyne administered. Sometimes it is necessary to take away a little blood; and we must always attend to the state of the bladder, prevent-

ing an accumulation of urine. When the symptoms are abated, a pessary must be introduced\*, and the woman may rise for a little, to ascertain how it fits; but, as in other cases, she ought for some time to keep much in a horizontal posture, and avoid for a still longer period every exertion.

If the tumor, from having been much irritated, or long protruded, be large, hard, inflamed, and perhaps ulcerated, it will be impossible to reduce it until the swelling and inflammation are abated, by a recumbent posture, fomentations, saturnine applications, laxatives, and perhaps even blood-letting†. After some days we may attempt the reduction, and will find it useful previously to empty the bladder. The reduction, in general, causes for a time, abdominal uneasiness. If the uterus cannot be reduced, and is much diseased, it has been proposed to extirpate the tumor. This has been done, it is true, with success<sup>68</sup>, but it is extremely dangerous; for the bladder is apt to be tied‡ by the ligature, which is put round the part; and as the intestines fall down above the uterus into the sac, formed by the inverted vagina, they also are apt to be cut || or constricted.

A prolapsus uteri does not prevent the woman from becoming pregnant<sup>69</sup>; and it is even of advantage that she should be become gravid, as we thus, at least for a time, generally cure the prolapsus. But we must take care, lest premature labour § be excited; for the uterus may not rise properly, or may again prolapse, if exertion be used.

Sometimes, especially if the person receive a fall<sup>70</sup>, or have a wide pelvis, the uterus may prolapse during pregnancy, although the woman have not formerly had this disease. Our first care ought to be directed to the bladder<sup>71</sup>, lest fa-

\* Dr Denman very properly advises, that a pessary should not be introduced immediately after the uterus is reduced. *Lond. Med. Journal*, Vol. VII. p. 56.

† M. Hoin succeeded in reducing a very large, hard, and even ulcerated procidentia, by fomentations, rest, and low diet. *Mem. de l'Acad. de Chir* Tome III. p. 365.

‡ This happened in Ruysch's case. *Obs. Anat.* vii.

|| This occurred in a case related by Henry, *ab Heers*, *Obs. Med.* p. 192.

§ Vide Mr Hill's case, in *Med. Comment.* Vol. IV. p. 88.

tal suppression of urine<sup>72</sup> take place. Our next object is to replace the uterus, and retain it by rest, and a pessary. If it cannot be reduced \*, the uterus must be supported by a bandage †, until, by delivery, it be emptied of its contents. It is then to be reduced. The management of prolapsus during labour, will be afterwards considered.

If prolapsus be threatened, or have taken place after delivery, in consequence, for instance, of getting up too soon, we must confine the woman to a horizontal posture, till it have regained its proper size and weight; and this diminution is to be assisted by gentle laxatives, particularly the daily use of the *sulphas potassæ cum sulphure*, in doses of from two to three drachms. The bandage formerly noticed, is also useful and comfortable.

In some cases, the cervix uteri lengthens and descends lower in the vagina, though the body of the womb remains in situ. This is not to be confounded with prolapsus, for it is really a preternatural growth of part of the uterus; and this portion, or elongation, has been removed by ligature.

#### SECTION THIRTY-NINTH.

Inguinal herniæ of the uterus have been long ago described by Sennert, Hildanus, and Ruysch, and very lately by Lallement. This species of displacement may occur in the unimpregnated state, and the woman afterwards conceive; or it may take place when pregnancy is somewhat advanced. If it be possible to reduce the uterus, this must be done; and in one stage, an artificial enlargement of the foramen, through which the uterus has protruded, may assist the reduction. If, however, gestation be far advanced, then the incision must be made into the uterus whenever pains come on, and the child must be thus extracted.

\* See a remarkable case in prolapsus in the gravid state, where the whole uterus protruded, and reduction was not accomplished till after delivery. By P. C. Fabricius, in Haller. *Disp. Chir. Tomus III. p. 434.*

† Vide *Memoirs* by M. Sabatier, in *Mém. de l'Acad. de Chir. Tome III. p. 379.*



## SECTION FORTIETH.

The ovarium is subject to several diseases, of which the most frequent is that called dropsy. The appellation, however, is not proper, for the affection is not dependent on an increased effusion of a natural serous secretion or exhalation, but is more akin to encysted tumors, and consists in a peculiar change of structure \*, and the formation of many cysts, containing sometimes watery, but generally viscid fluid, and having cellular, fleshy †, or indurated substance interposed between them, frequently in considerable masses. They vary in number and in magnitude. Sometimes there is only one large cyst containing serous fluid; but most frequently we have a great many in a state of progressive enlargement; the small ones are perhaps not larger than peas, others are as large as a child's head, whilst the one which has made most progress may equal in size the gravid uterus at the full time. The inner surface of the cysts may either be smooth, or covered with eminences like the papillæ of a cow's uterus ‡. Their thickness is various, for sometimes they are as thin as bladders, sometimes fleshy, and an inch thick. The fluid they contain is generally thick and coloured, and frequently foetid, and in some instances, mixed with flakes of fleshy matter, or tufts of hair; occasionally, it is altogether gelatinous, and cannot be brought through a small opening. The tumor has been seen made up entirely, or in part, of hydatids<sup>75</sup>.

This morbid affection of the ovarium sometimes begins with pretty acute pain about the groins, thighs, and side of the lower belly, with disturbance of the stomach and intestines, and occasionally syncope. Some patients feel pain

\* Le Dran says, this dropsy always begins with a scirrhus, and is only a symptom of it.—Dr Hunter says he never found any part of a dropsical ovarium in a truly scirrhus state.

† Dr Johnson's patient had the right ovarium converted into a fleshy mass, weighing nine pounds, and full of cysts. *Med. Comment.* Vol. VII. p. 265.

‡ I have seen the inner surface of the ovarium studded over with nearly a dozen of large tumours. M. Morand notices two cases, in which a similar structure obtained.

very early in the mammæ; and M. Robert affirms, that it is felt most frequently in the same side with the affected ovary. In some cases milk is secreted<sup>74</sup>. But generally the symptoms are at first slight, or chiefly dependent on the pressure of the parts within the pelvis. The patient is constipated, and subject to piles, has a difficulty in making water, or even a complete retention of urine; and sometimes one of the feet swells. By examining per vaginam, a tumor may often be felt betwixt the vagina and rectum, and the os uteri is thrown forward near the pubis; so that, without some attention, the disease may be taken for retroversion of the womb\*. In some time after this, the tumor, in general, rises out of the pelvis<sup>75</sup>, and these symptoms go off. A moveable mass can be felt in the hypogastric, or one of the iliac regions. This gradually enlarges, and can be ascertained to have an obscure fluctuation. The tumor is moveable, until it acquire so great size, so as to fill and render tense the abdominal cavity. It then resembles ascites, with which it in general comes to be ultimately combined<sup>76</sup>. As it rises, it sometimes presses on the fundus vesicæ, producing incontinence of urine, or on the kidney, making part of it to be absorbed; and it generally irritates the bowels, causing uneasy sensations, and sometimes hysterical affections†. It augments in size; and carries up the uterus with it‡; so that the vagina is elongated: and this is especially the case, if both ovaria be enlarged<sup>77</sup>. The urine is not in the commencement much diminished in quantity, unless this disease be conjoined with ascites; and the thirst, at first, is not greatly increased. But when the tumor has acquired a great size, the urine is generally much diminished or obstructed. If, however, the bulk be lessened artificially, it is often, for

\* Mr. Home's case related by Dr Denman, Vol. I. p. 130, had very much the appearance of retroversion.

† Case by Sir Hans Sloan, in Phil. Trans. No. 252.—Dr Pulteney's patient, whose ovary weighed fifty-six pounds, had excruciating pain in the left side, spasms, and hysterical fits. Mem. of Medical Society, Vol. II. p. 265.

‡ This point is well considered by M. Voisin, in the Recueil Period. Tome XVII. p. 371, et seq.—The bladder may also be displaced, as in the case of Mademoiselle Agan, related by Portal. Cours d'Anat. Tome V. p. 549.

a time, increased in quantity, and the health improved. This is well illustrated by the case of Madame de Rosney\*, who, in the space of four years, was tapped twenty-eight times: for several days after each puncture, she made water freely, and in sufficient quantity; the appetite was good, and all the functions well performed: but in proportion as the tumor increased, the urine, in spite of diuretics, diminished, and at last came only in drops. The woman generally continues to be regular for a considerable time, and may even become pregnant.

In the course of the disease, the patient has often attacks of pain in the belly, with fever, indicating inflammation of part of the tumor which may terminate in suppuration, and produce hectic fever; but in some cases, these symptoms are absent, and little distress is felt, until the tumor acquire a size so great as to obstruct respiration, and cause a painful sense of distention. Then the abdominal coverings are often so tender, that they cannot bear pressure; and the emaciated patient, worn out with restless nights, feverishness, want of appetite, pain, and dyspnoea, expires.

This disease has sometimes appeared to be occasioned by injury done to the uterus in parturition, as, for instance, by hasty extraction of the placenta; or by blows, falls, violent passions, frights, or the application of cold; but very often no evident exciting cause can be assigned.

In the first stage of this complaint, we must attend to the effects produced by pressure. The bladder is to be emptied by the catheter, when this is necessary; and stools are to be procured. It may be considered, how far, at this period, it is proper to tap the tumor from the vagina, and by injections or other means, endeavour to promote a radical cure. When the woman is pregnant, and the tumor opposes delivery, there can be no doubt of the propriety of making a puncture<sup>78</sup>, which is preferable to the use of the crotchet. But this has only been resorted to, in order to obviate particular inconveniences, and affords no rule of conduct in other cases, where no such urgent reason exists. I am in-

\* Portal Cours d'Anat. Tome V. p. 519.



clined to dissuade strongly from any operation at this period, because in a short time the tumor rises out of the pelvis; and then the patient may remain tolerable easy for many months, or perhaps for years. Besides, the ovarium in this disease contains, in general, many cysts; and as these, in the first stage, are small, we can only hope to empty the largest. Perhaps we may not open even that; and although it could be opened and healed, still there are others coming forward, which will soon require the same treatment. Puncturing, then, can only retard the growth of the tumor, and keep it longer in the pelvis, where its presence is dangerous.

When the tumor has risen out of the pelvis, we must, in our treatment, be much regulated by the symptoms. The bowels should be kept open, but not loose, by rhubarb and magnesia, aloetic pills, cream of tartar, or Cheltenham salt. Dyspeptic symptoms may sometimes be relieved by preparations of steel, combined with supercarbonate of soda, or other appropriate medicines, though their complete removal cannot be expected as long as the exciting cause remains. General uneasiness or restlessness, occasionally produced by abdominal irritation, may be lessened by the warm bath, saline juleps, and laxatives; whilst spasmodic affections are to be relieved by fœtids; and, if these fail, by opiates. If, at any time, much pain be felt, we may apply leeches, and use fomentations, or put a blister over the part. Upon the supposition of this disease being a dropsy, diuretics have been prescribed, but not with much success<sup>79</sup>, and often with detriment. Some have supposed, that diuretics do no good whilst the disease is on the increase; but that, when it arrives at its acme, they are of service. But this disease is never at a stand; it goes on increasing, till the patient is destroyed. When they produce any effect, it is chiefly that of removing dropsical affections combined with this disease; and in this respect, they are most powerful immediately after paracentesis. With regard to the power of diminishing the size of the ovarium, my opinion is, that they have no more influence on it, than they have over a mellicerous tumor on the shoulder.

In one case, fomentations and poultices appear to have discussed a tumified ovarium\*.

Having palliated symptoms until the distention becomes troublesome, we must then tap the tumor, which gives very great relief; and, by being repeated according to circumstances, may contribute to prolong life for a length of time<sup>60</sup>. As the uterus may be carried up by the tumor, it is proper to ascertain, whether it be the right ovarium or the left which is enlarged; and we should always tap the right ovarium on the right side, and *vice versa*: by a contrary practice, the uterus has been wounded†. When the disease is combined with ascites, it is sometimes necessary to introduce the trocar twice, and the difference between the two fluids drawn off is often very great.

Finally, it has been proposed, to procure a radical cure, by laying open the tumor, evacuating the matter, and preventing the wound from healing, by which a fistulous sore is produced; or by introducing a tent, or throwing in a stimulating injection. Some of these methods have, it is true, been successful<sup>81</sup>, but occasionally they have been fatal<sup>82</sup>; and in no case, which I have seen, have they been attended with benefit. There are two powerful objections to all these practices, besides the risk of exciting fatal inflammation: the first is, that the cyst is often irregular on its interior surface, and therefore cannot be expected to adhere: the second is, that as the ovarium, when dropsical, seldom consists of one single cavity, so, although one cyst be destroyed, others will enlarge, and renew the swelling; and, indeed, the swelling is seldom or never completely removed, nor the tumor emptied, by one operation. Hence even as a palliative, the trocar must sometimes be introduced into two or more places.

It has happened, that a cyst has adhered to the intestine<sup>83</sup>, and burst into it, the patient discharging glary or foetid matter by stool<sup>84</sup>. Such instances as I have known, have only

\* Vide Dr. Monro's fourth case, in Med. Essays, Vol. V.

† In a case of this kind related by M. Voisin, the uterus was wounded, and the patient felt great pain, and fainted. She died on the third day after the operation. Recueil period. Tome VII. p. 372, &c.

been palliated, but not cured, by this circumstance. Sometimes the fluid has been evacuated per vaginam<sup>85</sup>, or the ovarium has opened into the general cavity of the abdomen, and the fluid been effused there.

There is another disease, or a variety of the former disease, in which bones, hair, and teeth, are found in the ovarium<sup>86</sup>. The sac, in which these are contained, is sometimes large, and generally is filled with watery or gelatinous fluid. The bony substance, and teeth, usually adhere to the inner surface of the cyst. This disease produces no inconvenience, except from pressure. It has been deemed by some, to be merely an ovarian conception; but it may undoubtedly take place without impregnation, nay, similar tumors have been found in the male sex<sup>87</sup>. It is to be treated as the former disease.

#### SECTION FORTY-FIRST.

The ovaria are sometimes affected with scrophula, and the tumor may prove fatal by producing retention of urine. When it rises out of the pelvis, it is often productive of hypochondriasis, and very much resembles the ovarian disease, formerly mentioned, but is firmer, seldom gives a sensation of fluctuation, and sometimes is very painful when pressed. It rarely terminates in suppuration; but when it does, the fluid, as Portal observes, is *blanchatre, filamenteux, grumeleux, mal digere*. The substance of the ovarium is soft, and similar to that of other scrophulous glands. Occasionally it contains a cheesy substance, which is found, at the same time, in the mesenteric and other glands. Burnt sponge, cicuta, mercury, electricity, laxatives, &c. have been employed, but seldom with benefit. The most we can do, is to palliate symptoms, such as retention of urine, costiveness, dyspepsia, or pain.

The ovarium may also be enlarged, and become hard and stony<sup>88</sup>, or converted into a fatty substance<sup>89</sup>. Sometimes it is affected with the spongoid disease, and is changed into a substance like brain, with cysts containing bloody serum. The tumor in this disease, feels like a soft mass.



tic. It may burst thro' the abdominal parietis, and throw out large fungous excrescences. Frequently we find, on cutting an enlarged ovarium, that part of it resembles the spongoid structure, having bloody fungous cysts; part is like firm jelly, and part like cartilage, or dense fat. Often the uterus participates in the disease. I have seen a mass of this kind weigh thirteen pounds. I have never found the ovarium cancerous.

#### SECTION FORTY-SECOND.

The ovaria may be wanting on one or both sides, or may be unusually small. In such cases, it sometimes happens, that the growth of the external parts stops early, and the marks of puberty are not exhibited. The ovarium may form part of a herniary tumor.

#### SECTION FORTY-THIRD.

The tubes may be wanting, or impervious, and are subject to many of the diseases of the ovaria.

The round ligaments may partake of the disease of the uterus, or may have similar diseases, originally appearing in them. When they are affected, pain is felt at the ring of the oblique muscle, and sometimes a swelling can be perceived there.

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## CHAP. XI.

### *Of Menstruation.*

THE periodical discharge of sanguineous fluid, which takes place every month from the uterus, is termed the menses; and whilst the discharge continues, the woman is said to be out of order, or unwell.

In some instances, the discharge takes place at puberty, without any previous or attendant indisposition; but in most cases, it is preceded by uneasy feelings, very often by affections of the stomach and bowels, pain about the back and pel-

vis, and various hysterical symptoms. These affections, which are more or less urgent in different individuals, gradually abate; but at the end of a month, return with more severity, attended with colic pains, quick pulse, sometimes hot skin, and and a desire to vomit. There now takes place from the vagina, a discharge of a serous fluid, slightly red, but it does not in general become perfectly sanguineous for several periods. When the discharge flows, the symptoms abate; but frequently a considerable degree of weakness remains, and a dark circle surrounds the eye. In a short time the girl menstruates, often without any other inconvenience than a slight pain in the back, though sometimes, during the whole of her life, she suffers from many of the former symptoms every time she is unwell; and all women, at the menstrual period, are more subject than at other times to spasmodic and hysterical complaints.

When a girl begins to menstruate, certain changes take place, denoting the age of puberty. The uterus becomes more expanded, and receives its adult form; the vagina enlarges; the mons veneris swells up, and is covered with hair; the pelvis is enlarged; the glandular substance of the breasts is unfolded, and the cellular part increased; at the same time the mental powers become stronger, and new passions begin to operate on the female heart.

The age at which menstruation begins, varies in individuals, and also in different climates. It is a general law, that the warmer the climate, the earlier does the discharge take place, and the sooner does it cease. In Asia, for instance, the menses begin about nine years of age; whilst in the North, a woman does not arrive at puberty until she is eighteen or twenty years old; nay, if we may credit authors, in very cold countries, women only menstruate in the summer seasons. In the temperate parts of Europe, the most common age at which the menses appear, is thirteen or fourteen years.

The quantity of the discharge varies, also, according to the climate and constitution of the woman. In this country from six to eight ounces are lost at each menstrual period; but this does not flow suddenly; it comes away slowly for the

space of three or four days. Some women discharge less than this, and are unwell for a shorter space of time: others, especially those who live luxuriously, and are confined in warm apartments, menstruate more copiously, and continue to do so for a week.

In this country, menstruation ceases about the forty-fourth year, lasting for a period of about thirty years. In the East, the menses begin soon, flow copiously, and end early; the women in Asia, for example, being old, whilst the Europeans are still in their prime. In the north, the menses begin late, flow sparingly, and continue long.

The menses are obstructed during pregnancy, and the giving of suck; but if lactation be very long continued, the menses return, and the milk disappears or becomes bad.

The discharge appears to be yielded by the uterine arteries, but it is not an extravasation or hemorrhage, for when collected, it does not separate into the same parts with blood, neither does it coagulate. In many instances, a great quantity has been retained for many months in the uterus and vagina, but it has never been found clotted when it was evacuated,

Menstruation has been attributed to the influence of the moon, to the operation of a ferment in the blood, or in the uterus, to the agency of a general, or local plethora, or to the existence of a secretory action in the uterus. The last of these is the most probable opinion; but as this work is meant to be practical, I think it wrong to devote more time to the discussion of theories and speculations. The use of menstruation, seems to be to preserve the womb in a fit state for impregnation; at least, we know, that the presence of menstruation is generally necessary to, and indicates a capability of, conception.

As the female system is more irritable during menstruation than at other times, and as changes effected in the system, or in particular organs, at that time, may come to interfere with the due performance of the uterine action, it is



a general and proper custom with physicians, and a practice consonant to the prejudice of women themselves, not to administer active medicines during the flow of the menses. It is also proper, that indigestible food, dancing in warm rooms, sudden exposure to cold, and mental agitation, especially in hysterical habits, be avoided as much as possible: By neglecting these precautions, the action may either be suddenly stopped, or spasmodic and troublesome affections may be excited.

## CHAP. XII.

### *Of Diseased States of the Menstrual Action.*

#### SECTION FIRST.

AMENORRHŒA, or absence of the menses, has been divided into the retention, or *emansio mensium*, and the suppression of the menses. By the first term, we are to understand; that the menses have not yet appeared, the action being longer than usual of being established. By the second, is meant the interruption of the action which has already been established, and hitherto performed.

The retention of the menses is very generally attended with chlorosis, or a feeling of weariness and debility, with dislike to active employment; a pale or sallow complexion, cathectic appearance, œdematous swelling of the legs and feet; costiveness, complaints of the stomach, such as flatulence, acidity, loathing of food, but craving for indigestible substances, as chalk, lime, or cinders; pains of the head, and different parts of the body; swelling of the belly, with hysterical symptoms, such as palpitation, or dyspnœa; and if this state be not soon removed, it is apt to end either in consumption or dropsy.

The menses, may, from one person not arriving so early as another at puberty, be longer of appearing in some women than in others; and in such cases, no peculiar inconvenience attends the retardation. But when the retention proceeds

from other causes, it is to be considered as a disease; and generally, is to be attributed to a want of vigour in the system; by which, not only a new action is prevented from being formed, but also those which were formerly performed become impaired. In some cases, indeed, the absence of the menses depends upon a malformation of the organs of generation, a deficiency of the ovaria, or an imperfect development of the uterus; but in far the greatest number of instances, the action is postponed, merely from general debility of the system; and accordingly, the most successful mode of treatment consists in improving the health, and increasing the strength of the patient. This is to be done by regular exercise, proportioned to the ability of the person; the use of the hot salt water bath every day, succeeded by frictions with dry flannel, or a soft brush; a nourishing and digestible diet, with a proper portion of wine; avoiding every thing which disagrees or ferments; the administration of tonic medicines, particularly preparations of iron, such as chalybeate waters, tincture of muriated iron, or the carbonas ferri precipitatum combined with myrrh. The use of the Bath waters, internally as well as externally, is of service in the chlorotic state, but hurtful if the patient be of a full habit. In that case, purgatives are of most benefit. Strict attention must indeed in every case be paid to the state of the bowels. This is necessary in plethoric habits, to lessen the fluids, and in the chlorotic condition to stimulate the system; for in that case, the bowels are generally torpid, and communicate a similar debility to the rest of the system. The aloetic or compound rhubarb pill should be freely employed. The cold bath in chlorosis is seldom proper, as it is apt to be followed by chilliness, headach, and languor. It is only useful when succeeded by a sense of heat and comfort. The warm salt water bath is generally of greater service. Besides this general plan, it has also been proposed, to excite more directly the uterine action, by marriage, and the use of emmenagogues; but with respect to the latter part of the proposal, I must observe, that some of these, if rashly em-

ployed, may, from their stimulating qualities, do harm; and they do not generally succeed without the use of such means as tend to invigorate and improve the system. Should the tonic plan, however, fail, than we may employ some of those medicines, which will be presently mentioned. If retention should be combined with a plethoric state, the best plan is to use purgatives regularly, in a degree proportioned to their affect on the system, and make the patient take as much exercise as she can do without producing fatigue.

Suppression of the menses is naturally produced by pregnancy, and, very generally, by such diseases as tend greatly to weaken the patient. The first of these causes is soon recognised, by its peculiar effects. In the second, the effect is often mistaken for the cause; the bad health being attributed to the absence of the menses, and much harm frequently done by the administration of stimulating medicines. But in such cases it will be found, upon inquiry, that before the menses were suppressed, the patients had begun to complain. In them, the irregularity of the menses is symptomatic, and generally indicates considerable debility; induced, perhaps, by great fatigue, bad diet, loss of blood, or long continued serous discharge, hectic fever, or dyspepsia. Such causes, likewise, as operate more directly in weakening the uterus, as for instance abortion, or excessive venery, may produce, for a longer or a shorter period, a suppression of the menstrual discharge.

Suppression of the menses may be likewise suddenly occasioned by the operation of such causes, during menstruation, as can interfere with, or give disturbance to the action; such as cold, and passions of the mind. The suppression so produced may be quickly followed by disagreeable effects; and either owing to these effects injuring the health, or to the uterus not speedily recovering from the original affection, the suppression may continue for some months.

The immediate, and remote effects of suppression, are much modified by the previous state of the system, particularly with regard to irritability and plethora; and also by



the condition of individual organs \*, which, if already disposed to disease, may thus be excited more speedily into a morbid action. In many cases, nausea, tumor of the belly, and other indications of pregnancy, are produced.

It also sometimes happens, that in consequence of suppression of the menses, hemorrhage takes place from the nose, lungs, or stomach; and these discharges do, occasionally, observe a monthly period, but oftener they appear at irregular intervals.

When suppression of the menses takes place in consequence of some chronic and obstinate disease, such as consumption or dropsy, it would be both useless and hurtful to attempt, by stimulating drugs, to restore menstruation. But in those cases, where the menses are suppressed in consequence of cold, fear, or some removeable cause, inducing debility of the frame, it is proper to interfere, both as the suppression is a source of anxiety to the patient, and also as the rational means of restoration tend to amend the health.

It is proper, in our curative plan, to recollect, that the suppression may take place in different circumstances of the constitution. It may occur with a debilitated chlorotic condition, in which case we are to proceed much in the same way as in retention of the menses; and along with the tonic plan of treatment, it will be proper to have recourse to the use of emmenagogue medicines, such as savin †, hellebore ‡, myrrh, madder, or nitrous acid; and of these, the two first are the most active. About the time when the menses are expected to appear, it is sometimes of advantage to exhibit an emetic, and to make use of the warm bath or semicupium or pediluvium. Tourniquets have, about this time, been applied to the thighs, but not with much benefit.

\* Baillon has observed, that both in young girls, and elderly women, when the menses are obstructed or irregular, the spleen sometimes swells; and subsides again, when the menses become regular. *De Virgin. et Mulier. Morbis.* Tomus IV. p. 75.

† From 5 to 10 grains of the powdered leaves may be given three or four times a day.

‡ A dram of the tincture may be given twice or thrice daily.

Electricity, directed so as to act on the uterus, is occasionally of service.

When along with suppression of the menses, there is a febrile state, marked by heat of the skin, frequent pulse, flushing of the face, and irregular pains in the chest or abdomen, stimulating medicines are hurtful. It is, in this state, of advantage, to keep the bowels open, by the daily use of some saline purgative, dissolved in a considerable quantity of water: and should there be dyspœna, with pain about the chest, increased by inspiration, it will be proper to take away some blood. Should the skin still remain hot, the common saline julap will be of service. The febrile symptoms being removed, much advantage may be derived from a combination of myrrh, oxyde of iron, and the supercarbonate of potash; and should emmenagogues be thought advisable, the black hellebore is the best.

When a woman, upon the sudden suppression of the menstrual discharge, complains immediately of pain in the back and uterine region, or in the bowels, with or without febrile symptoms, the semicupium, and opiates combined with ipecacuanha, or the saline julap, will be of great service; or, if the symptoms be severe, some blood must be taken from the arm, and the bowels are to be opened. Should the menses not return at the next period, we must proceed as has been already directed.

Chlorosis, succeeding to abortion, laborious parturition, or fever, is often attended with symptoms much resembling phthisis pulmonalis. In many instances the pulse continues long frequent; there is nocturnal perspiration; considerable emaciation, with cough and pains about the chest; and yet the person is not phthisical, she suffers chiefly from debility; but if great attention be not paid to improve the health, the case may end in consumption; and hence many consumptive women date the commencement of their complaints from an abortion, or from the birth of a child, succeeded by an hemorrhage. In chlorosis, the symptoms are induced, not by previous pulmonic affections, but by some other evident cause of weakness; the pulse, although frequent, is not liable

to the same regular exacerbation, as in hectic; a full inspiration gives no pain, and little excitement to cough; the person can lie with equal ease on either side; the cough is not increased by motion, nor by going to bed, but it is often worst in the morning, and is accompanied with a trifling expectoration of phlegm. It is not short, like that excited by tubercles, but comes in fits, and is sometimes convulsive; whilst palpitation, and many hysterical affections, with a timid and desponding mind, accompany these symptoms. The bowels are generally costive, and the person does not digest well

In chlorosis, attended with symptoms resembling phthisis, it is of considerable utility, to administer occasionally, a gentle emetic, and at the same time the bowels must be kept open. Myrrh, combined with the oxyde of zinc, is, I think, of approved efficacy; and the ammonia, given in the form of an emulsion with oil, very often is effectual in relieving the cough. A removal to the country, and the use of moderate exercise on horse-back, will contribute greatly to the recovery. The diet ought to be light, but nourishing. In many cases, milk agrees well with the patient, but it is not necessary to restrict her from animal food. Pain in the side may be removed, by the application of a warm plaster; and, if the cough be troublesome, the squill may be used as an expectorant, and an opiate should be given at bed-time. If the skin be permanently hot, or irregularly hot and cold, without weakening perspiration, the tepid bath is of service, or small doses of saline julap may be given. Should the person be of a phthisical habit, and the symptoms increase or continue obstinate, it will be proper to remove her to a mild climate, or the southern part of the island. Emmenagogues are either useless or detrimental.

#### SECTION SECOND.

It sometimes happens, that the uterus, instead of discharging a fluid every month, forms a membranous or organized substance, which is expelled with pains and hem-



orrhage, like abortion. Morgagni\* describes this disease very accurately. The membrane, he says, is triangular, corresponding to the shape of the uterine cavity; the inner surface is smooth, and seems as if it contained a fluid; and that it does so, I have no doubt from my own observation; the outer surface is rough and irregular. According to Morgagni, the expulsion is followed by lochial discharge.

Dr Denman supposes, that no woman can conceive who is affected with this disease; but some cases, and amongst others, that related by Morgagni, are against this opinion. Mercury, bark, chalybeates, myrrh, and injections, have all been tried, but without much effect. Time, in general, removes the disease better than medicine, which is only to be advised for the relief of pain, weakness, or any other symptom which may attend, or succeed to this state. A knowledge of this disease may be of great importance to the character of individuals.

#### SECTION THIRD.

Some women menstruate with great pain, and the discharge generally takes place slowly. This disease is called dysmenorrhœa. It seems to be dependent on an imperfect menstrual action; and this opinion is supported by observing, that mild emmenagogues give relief, but those of a stimulating quality are not so proper. Saffron, madder, or rue, are often of service; at the same time, the warm bath, or semicupium, is to be employed for a day or two previous to menstruation, and should be repeated every night, during its continuance. Opiates, combined with ipecacuanha, or anodyne clysters should also be given, to abate the pain; and the bowels are to be kept open, by mild saline laxatives. Spasm of the bowels, and suppression of urine or strangury accompanying this disease, are relieved by the semicupium and antispasmodics.

#### SECTION FOURTH.

The menses may be abundant in quantity, at the regular

\* Vide Epist. XLVIII. art. 12.

period; or they may return too copiously, once in three weeks, or even more frequently. This morbid condition, which is called menorrhagia, may take place, either along with a considerable frequency of pulse, and febrile heat, sometimes preceded by chilliness; or with languor, cold skin, and marks of torpor, and debility of the arterial system. In both cases, the discharge is generally accompanied with pain in the back and uterine region. The fluid evacuated is of two kinds; the menstrual secretion increased in quantity, which does not coagulate, but is sometimes preceded, and succeeded by a slight discharge of brownish serum; and pure blood, which often forms coagula in the vagina. All profuse discharges are of this last kind. In some cases, there is a constant stilicidium of blood, except for a day before and after menstruation.

When the hemorrhage is considerable, or frequently repeated, it produces the usual effects of loss of blood, and may thus either immediately or remotely prove a cause of death. When the hemorrhage is more moderate, or when the menstrual discharge is only somewhat increased in quantity, or repeated at shorter intervals than a lunation, the constitution suffers more slowly, and in many cases very slightly, the woman being only somewhat weaker than usual. This state, however, may dispose to other diseases, and it proves a cause of sterility.

Copious menstruation often proceeds from irritation of the uterus, or the repeated excitement produced by excessive venery. It may also be occasioned by debility of the uterine system, brought on by abortion, or frequent and laborious parturition; or it may be connected with general feebleness of the constitution. In some cases, it appears to arise from that state of the arteries which disposes to hemorrhage; and that is particularly the case in those who are of a delicate make, and inclined to phthisis.

Hemorrhage from the uterus is different from copious menstruation, and is generally dependent either upon those remote and occasional causes which produce hemorrhage from other vessels, or on an enfeebled, but overacting state of the uterine vessels, existing during the time of menstruation.

ation: and hence, in low fevers, a very copious discharge of blood sometimes takes place from the uterus, and proves fatal with great rapidity.

Married women are much more subject to increased menstrual discharge than virgins; and it is very rare for the latter, especially if healthy, to be affected with hemorrhage from the womb.

The hemorrhage from the uterus is to be managed upon general principles. When it depends upon plethora, or strong action of the vessels, we must have, if the pulse require it, recourse to blood-letting, and give digitalis to make the circulation slower. If the pulse be not full and strong, and the patient robust, blood-letting is improper. In every case, unless she be cold and exhausted, we apply cold both generally and locally. The patient always must be kept at rest in an horizontal posture; and opiates are to be given if there be much pain and irritation. The food ought to be sparing, and every thing warm is to be avoided. If necessary, the vagina is to be plugged. If a great effect have been produced upon the system by the hemorrhage, then the strength must be supported by nourishment and cordials, and liberal doses of opium will be found of much benefit. In order to prevent a return, the patient, if plethoric, must be put on spare and dry diet, the sleep abridged, the exercise increased, the bowels kept open by mild laxatives, but not clysters, and, at the same time, the constitution is to be invigorated by the cold bath, which is by no means incompatible nor inconsistent with the other means. When the hemorrhage depends on debilitating causes, such as typhus fever, we trust chiefly to the plug, and support the strength by cordials. In neither case have astringents given internally, any very great effect, but if any are to be employed, alum whey or sulphuric acid are the best. Styptic injections are often of singular utility. In repeated discharges, emetics are sometimes of service, by exciting uterine contraction. M. Gendron, in the Seventh Volume of the *Recueil Periodique*, relates an excellent instance of their effects on a woman, who had obstinate and alarming hemorrhage,



which resisted even the use of the plugs, and caused frequent syncope. The discharge stopped after giving ipecacuanha.

Stillicidium is best cured by astringent injections.

In copious, or too frequent menstruation, we must, if the patient be plethoric, the skin warm, and the pulse above the usual standard, sometimes detract blood; but generally it is better to keep the bowels lax, and give occasionally saline julaps or antimonials, till the febrile state be removed: after which the disease may go off, but if not, tonics will then do good. In the great majority of cases, however, there is rather an opposite state of the system, requiring a directly invigorating plan, such as the cold bath, preserving the bowels in a regular state, gentle exercise in the country, the use of a nourishing and easily digestible diet, with wine and tonic medicines, or chalybeate water, such as that of Tunbridge. Sometimes the use of the aqua ammoniæ, in considerable doses, is attended with great advantage: cold water may, with much benefit, be poured daily upon the back, and injected frequently into the vagina. In obstinate cases, emetics, such as ipecacuanha, or the sulphate of zinc, are of service. It is necessary to avoid whatever may act as an exciting cause, such as heated and crowded rooms, much dancing, long walks, venery, &c.

Sometimes the woman menstruates every fortnight, but the discharge which continues for the usual time, is alternately red and albuminous. This state seems to depend on weakness, and is cured by tonics.

Symptomatic discharges, produced by polypus, cancer, &c. have already been considered.

## CHAP. XIII.

### *Of the Cessation of the Menses.*

ABOUT the period when the menses should cease, they become irregular, and sometimes are obstructed for two or three months, and then for a time return. This obstruction, like many other cases of retention and suppression of

the menses, is accompanied with swelling of the belly, sickness, and loathing of food. These effects are frequently mistaken for pregnancy : for, as La Motte remarks, many women have such a dislike to age, that they would rather persuade themselves they are with child, than suppose they are feeling any of the consequences of growing old ; and this persuasion they indulge like Harvey's widow, *donec tandem spes omnis in flatum et pinguedinem facesseret*. In this situation, the belly is soft and equally swelled, and enlarges more speedily after the obstruction, than it does in pregnancy. No motion is felt, or if it be, it is from wind in the bowels, and shifts its place. Exercise, chalybeates and laxatives, are the proper remedies in this case.

The period at which the menses cease, or "the time of life," is considered as critical, and, without doubt, it is an important epoch. If there be a tendency to any organic disease, it is greatly increased at this time, more especially, if it exist in the uterus or mammæ : and, indeed, the cessation of the menses does of itself seem, in some cases, to excite cancer of the breast. Diseases of the liver, also, make greater progress at this period, or first appear soon after it. Dyspeptic affections are still more frequent. When there is no tendency to local disease, it is very common for women, after the menses cease, to become corpulent, and sometimes they enjoy better health than formerly.

From an idea of the cessation of menstruation being uniformly dangerous, some, by the use of emmenagogues, tried to prolong the discharge, others, by issues, endeavoured to prevent bad effects. The first of these means is foolish and hurtful, the last is not necessary. When the health is good, no particular medicines are requisite ; but if there be a tendency to any peculiar disease, then the appropriate remedies must be employed. The bowels must be kept open.

## CHAP. XIV.

*Of Conception.*

CONCEPTION seems to depend upon the influence of the semen exerted on the ovaria, through the medium of the rest of the genital system; for women have conceived, when semen has been applied merely to the vulva, the hymen being entire. In consequence of this, an ovum is excited into action; it enlarges; the peritoneal covering becomes more vascular, and is made to protrude a little. Then that part which covers the vesicle is absorbed, whilst the vesicle itself escapes into the fallopian tube, which had, at the time of impregnation, embraced the ovarium; and thus it is conveyed into the uterus. When the ovum is received into the tube, and either carried into the womb, or brought a certain way along the canal, the tube loosens from the ovarium, and the absorbed spot on the surface of the ovarium is perceptible. This afterwards forms a kind of cicatrix, called corpus luteum.

It would appear, that although an ovum be impregnated, yet, by various causes, the process afterwards may be interrupted; the ovum shrivels, and is absorbed. If there be an impervious state of the tubes, or any conformation or condition, rendering it impossible for a child to be supported, the ovum decays, and the woman is barren. Or if such a state be induced after impregnation, and before the ovum descends, the process stops\*.

In the human subject, only one ovum is generally impregnated by one seminal application, but sometimes two or more may be carried down into the uterus; and even after one ovum has reached the uterus, and grown to a certain degree within it, we find, that it is possible for a second to be excited into action, and brought down into the womb, where it is nourished and supported†.

\* Dr. Haighton found, that by dividing the tubes, after a rabbit was impregnated, the ova were destroyed. Or if only one tube was cut, and the female afterwards became impregnated, corpora lutea were found in both ovaria, but no ova were found in the tube or horn of the uterus, on the injured side. Phil. Trans. Vol. LXXXVII. p. 175, &c.

† Vide Med. and Phys. Journ. Vol. XVII. P. 489.



From the experiments of Mr Hunter\*, it is probable, that each ovarium is capable of producing only a certain number of ova: and that if one ovarium be removed or rendered useless, the constitution cannot give to the other the power of producing as many ova as could have been done by both.

It has been attempted to ascertain what age, and what season was most prolific. From an accurate register made by Dr Bland, it would appear, that more women between the age of twenty-six and thirty years, bear children, than at any other period. Of 2102 women, who bore children, 85 were from fifteen to twenty years of age; 578 from twenty-one to twenty-five; 699 from twenty-six to thirty, 407 from thirty-one to thirty-five; 291 from thirty-six to forty; 36 from forty-one to forty-five; and 6 from forty-six to forty-nine.

At Marseilles, M. Raymond says, women conceive most readily in Autumn, and chiefly in October; next in Summer; and lastly in Winter and Spring; the month of March having fewest conceptions. M. Morand again says, that July, May, June, and August, are the most frequent dates of conception; and November, March, April, and October, the least frequent in the order in which they are enumerated. I have been favoured with a register, for ten years, of an extensive parish in this place; from which it appears, that the greatest number, both of marriages and births take place in May, and the fewest births in October. From this we would consider August and September to be most favourable to conception; but it is evident, that these conclusions are liable to great uncertainty.

Women are supposed to conceive most readily immediately after the menstrual evacuation, but it is doubtful how far this opinion is correct; and therefore, in calculating the time when labour should be expected, it is usual to count from a fortnight after the last appearance of the menses, or to say that the woman will be confined at the end of the forty-second week from that period.

\* Vide Phil. Trans. Vol. LXXVII

The process of gestation usually requires forty weeks, or nine calendar months for its completion; but many circumstances may render labour somewhat premature, and it is even possible for the process to be completed, and the child perfected to its usual size, a week or two sooner than the end of the ninth month. On the other hand, it is equally certain, that some causes, which we cannot explain nor discover, have the power of retarding the process, the woman carrying the child longer than nine months\*; and the child, when born, being not larger than the average size. How long it is possible for labour to be delayed beyond the usual time, cannot easily be ascertained; but it is very seldom protracted beyond a few days, counting the commencement of pregnancy, from the day preceeding that on which the menses ought to have appeared, had the woman not conceived.

## CHAP. XV.

### *Of the Gravid Uterus.*

#### SECTION FIRST.

WHEN we compare the unimpregnated with the gravid uterus at the full time, we must be astonished at the change which has taken place during gestation, in its magnitude alone.

In the ninth month, the size of the womb is so much increased, that it extends almost to the ensiform cartilage of the sternum; and this augmentation it receives gradually, but not equally, in given times; for it is found to enlarge much faster in the latter, than in the earlier months of pregnancy. This is true, however, only with regard to the absolute increase; for in the first month, the uterus perhaps doubles its original size, but it does not go on in the same ratio. It is not twice as large in the ninth as in the eighth month.

\* By the law of this country, a child born six months after the marriage of the mother, or ten months after the death of the father, is considered as legitimate.

For a considerable time after conception, the uterus instead of rising higher up into the belly, falls rather lower down. It is not till towards the end of the third month, that the uterus can be felt rising above the pubis; although at this period, it generally measures from the mouth to the fundus above five inches, one of which belongs to the cervix. In the fourth month, it reaches a little higher, and measures five inches from the fundus to the beginning of the neck. In the fifth, it has become so much larger, as to render the belly tense, and may be felt, like a ball, extending to a middle point between the pubis and the navel, and measures about six inches from the cervix to the fundus. In other two months, it reaches to the navel, and measures about eight inches. In the eighth month, it ascends still higher; reaching to about half way between the navel and the sternum. In the ninth month, it reaches almost to the extremity of that bone, at least in a first pregnancy, when the tightness of the integuments prevents it from hanging so much forward as it afterwards does. At this time, it generally measures, from top to bottom, ten or twelve inches; and is oviform in its shape. For the first month, the shape of the uterus is not altered; it is enlarged in every direction. But after this it swells before and behind, and soon becomes globular, having the cylindrical undistended cervix depending from it; after the fifth month it becomes more oblong, and by the seventh it resembles a balloon. These calculations are not invariably exact, suiting every case, but admit of modifications.

In pregnancy, the mouth of the uterus is directed backward, whilst the fundus lies forward. This obliquity, however, does not take place until the uterus begins to rise out of the pelvis, and it always exists in a greater degree in those who have born many children.

From this position it appears, that the intestines can never be before the uterus, but must lie behind it and round its sides.



## SECTION SECOND.

Previous to the descent of the ovum, the uterus begins to enlarge, especially at its upper part, or fundus; and it is worthy of notice, that the posterior face of the uterus always distends more than the anterior one, as we ascertain by examining the situation of the orifices of the fallopian tubes.

When the fundus begins to increase, it not only grows heavier, but also presents a greater surface for pressure to the intestines above: it, therefore, will naturally descend lower down in the pelvis, and thus project farther into the vagina. In this situation the uterus will remain, until it becomes so large as to rise out of the pelvis.

Until this ascent of the uterus, which takes place about the fourth month, the fundus and body form the whole of the cavity; but then the cervix begins also to be developed: so that by the end of the fourth month of pregnancy, one quarter of its length has become distended, and contributed to augment the uterine cavity; the other three fourths, which remain projecting, become considerably softer, rather thicker, and more spongy. In another month, one half of the cervix is distended, and the rest is still more thickened, or the circumference of the projecting part greater: the uterus has also risen farther up, consequently the vagina is more elongated. In the sixth month, the neck is still more stretched. In the seventh, we may, with the finger, distinguish the head of the child pressing on the lower part of the uterus, which we can seldom do before this. In the eighth month, the neck is completely effaced, and its orifice is as high as the brim of the pelvis. The ninth month affects the mouth of the uterus chiefly. The alterations of the cervix are discovered, by introducing the finger into the vagina, and estimating the distance betwixt the os uteri and the body of the uterus, which we feel expanding like a balloon.

The mouth of the uterus is merely the termination or extremity of the cervix, and consists of two lips of the same consistence with the rest of the uterus. When the

womb is not gravid, these are always open, and will admit the tip of the finger. But, soon after conception, the os uteri is closed, except at the very margins, at the same time that it gradually becomes softer. In proportion as pregnancy advances, and the cervix stretches, the lips shorten, until they sometimes totally disappear; but more frequently they continue to project a little, until labour commences. The lower part of the cervix, in the course of gestation, and the inner border of this opening, in the ninth month, for about an inch round, is full of glandular follicles, which secrete a thick viscid mucus. This extends from the one side to the other, and fills up the mouth of the uterus very perfectly, being thus interposed as a guard betwixt the membranes and any foreign body. By maceration, it may be extracted entire, when a mould of the lacunæ will be obtained by floating it in spirits, saturated with fine sugar.

#### SECTION THIRD.

VESALIUS describes three strata of muscular fibres, transverse, perpendicular, and oblique. Malpighi describes them as forming a kind of net-work; whilst Ruysch maintains, that they appear at the fundus, in concentric planes, forming an orbicular muscle. Dr Hunter paints them as transverse in the body of the uterus, but, at the fundus, describing concentric circles around each of the fallopian tubes. These contradictions of anatomists serve to shew, what may readily be seen by examining the uterus, that the fibres are not very regular and distinct in their course, but exhibit confusion, rather than any well marked figure.

The increased size of the uterus is by no means chiefly owing to the addition of muscular fibres. These become indeed larger, and better developed, but do not contribute so much to the increase, as the enlargement of the blood vessels, and perhaps the deposition of cellular substance. This gives the uterus a very spongy texture, and makes it so ductile, that a small aperture may be greatly dilated, without tearing. From examination, it appears, that although the whole uterus does not grow thinner in proportion to its increase, it yet does, at the full time, become

thinner near the mouth; whilst the fundus continues the same, or perhaps grows a little thicker, at least where the placenta is attached.

#### SECTION FOURTH.

No one, who understands the anatomy of the ligaments of the unimpregnated uterus, will be surprised to find a great change produced in their situation and direction, by pregnancy. The broad ligament, which is only an extension of the peritoneum from the sides of the uterus, is, in the ninth month, by the increase of the viscus, spread completely over its surface; and consequently, were we to search for this ligament, we would be disappointed. Its duplicatures are all separated, and laid smoothly over the uterus. It will therefore be evident, that we can no longer find the ovaria and fallopian tubes floating loose in the pelvis, nor the round ligaments running out at an angle from the fundus uteri to the groin. All these are contained within duplicatures of the peritoneum, or ligamentum latum; and therefore, when this is spread over the uterus, it follows, that the ovaria, tubes, and round ligaments, cannot now run out loosely from the uterus, but must be laid flat upon its surface, and bound down by the stretched peritoneum. This description applies only to the state of the uterus in the full time. Earlier, we may readily observe the broad ligament flying out, and allowing the ovaria free play. The loose extremity of the tube becomes more expanded, and very vascular.

On the ovarium we observe a corpus luteum. This is a substance something like a gland, divisible into cortical and medulary matter, placed immediately under the membrane of the ovarium, and adhering to the ovarium by cellular substance. By separating this, it can be turned out. It is of a yellowish colour, and is largest soon after conception. There is a corpus luteum for every foetus.

#### SECTION FIFTH.

The origin, and distribution of the blood-vessels of the uterus have been already noticed; I have only to add, that



in pregnancy, they become prodigiously enlarged. Even before the ovum enters the uterus, we find the uterine artery as large as the barrel of a goose quill, and sending large branches round the cervix uteri, and up the sides of the womb. As pregnancy advances, the trunks, but especially the branches, become still larger, particularly near the implantation of the placenta. The veins are enlarged in the same proportion with the arteries. They are destitute of valves, and receive the name of sinuses.

The lymphatics are very large and very numerous. The nerves have already been described.

#### SECTION SIXTH.

Although many opportunities have occurred to anatomists, of examining not only abortions, but also the uterus itself, at an early period of gestation; yet it has not been exactly determined at what precise time the ovum enters the womb, or when the foetus first becomes visible. This may depend, partly on want of information respecting the exact number of days which have intervened betwixt impregnation and our examination; and partly, perhaps, upon irregularities of the process in the human female, induced by various causes.

We know that considerable changes take place in the cavity of the uterus, before the ovum descends, and these generally are not accomplished in less than twenty or thirty days. In a very accurate dissection performed by the late Mr Hunter, and related by Mr Ogle\*, no ovum could be found either in the uterus or the tubes, although there is reason to suppose that nearly a month had elapsed from the time of impregnation. I have examined very carefully three uteri about the same period, and have not been able to discover either ovum or foetus. If we admit analogical evidence on this subject, we shall be more confirmed in a belief that the ovum does not, in the human female, enter the uterus, until at least three weeks after conception†. In the

\* Transaction of a Society, &c. vol. II. Art. vi.

† Dr Combe possessed a preparation, where there was an appearance of a very minute foetus. From peculiar circumstances, two and twenty days were supposed to have elapsed from the time of conception. Vide Dr Hunter's Anatomy, Description, p. 67.

rabbit, whose period of gestation is only thirty days, the ovum is not to be found in the uterus earlier than the fourth day, according to Mr Cruikshank \*, or the sixth according to Dr Haighton ; and the foetus is not visible till the eighth day, when it may be seen by dropping vinegar on the ovum †. Haller found, that in the sheep, whose term of gestation is five months, the ovum does not enter the uterus till the seventeenth day ‡, and the foetus is not visible till the nineteenth.

The ovum, at first, contains no visible embryo ; nothing but vesicular involucra appear. This point is fully established by examining the inferior animals, and is especially confirmed by the incubation of the eggs of fowls.

When the human foetus is first distinctly visible through the membranes, it is not above a line in length, and of an oblong figure. By the sixth week, it is seen slightly curved, resembling, as it floats in the water, a split pea. In the seventh week, it is equal in size to a small bee ; and, by the conclusion of the second month, it is bent and as long as a kidney bean.

The embryo, at first, appears like two oval bodies of unequal size, united together by a neck. The one of these is the head, the other the trunk. The head is a membranous bag, which is large in proportion to the body ; but after the first month of its growth, the relative size decreases: on opening it, nothing but a soft pulp is found within. In a little time, the face appears, the most prominent features of which are the eyes ; these are proportionally larger in the embryo than in the advanced foetus, and are placed low down. The face itself is small, compared to the cranium. The nose does not appear until the end of the second month ; but somewhat sooner, we may observe two apertures in the situation of the nostrils. The mouth, at first, is a round hole, but by degrees lips appear ; and after the third month, they are closed, but do not cohere. The external ear is not

\* Phil. Trans. Vol. LXXXVII.

† Phil. Trans. Vol. LXXXVII. p. 204.

‡ Elementa, Tom. VIII. p. 59.—Opera Moinora, Tome II. p. 434.

formed at once, but in parts, and is not completed before the fifth month; even then, it differs in its shape from the ear after birth. It is at first like a gently depressed circle.

The extremities early appear like the buds of a plant. The arms are directed obliquely forward, toward the face, and are larger than the inferior extremities. The genitals, for a time, are scarcely to be observed; but in the third month, they are large in proportion to the body.

The foetus does not grow in an uniform ratio, but, as has been observed, by the learned anatomist, Dr Soemmerring, the increment is quicker in the third than in the second month. In the beginning of the fourth it becomes slower, and continues so until the middle of that month, when it is again accelerated. In the sixth month, it is once more retarded, and the progression remains slow during the rest of gestation.

The proportion between the weight of the foetus and its involucre, is reversed at the beginning and the end of gestation. When the embryo does not weigh more than a scruple, the membranes are as large as a small egg. Even when the foetus is not larger than a fly, the membranes resemble, in shape and size, a large chesnut. On the other hand, at the full time, when the foetus weighs seven pounds, the placenta and membranes do not weigh a pound and a half, and the proportion of liquor amnii is greatly lessened. In the twelfth week, the foetus weighs nearly two ounces, and measures, when stretched out, about three inches. The membranes are larger than a goose's egg, and weigh, if we include the liquor amnii, several ounces. In the fourth month, the foetus is about five inches long. In the fifth month, it measures six or seven inches. In the sixth month, the foetus is perfect and well formed, measures eight or nine inches, and weighs about one pound troy; whilst the placenta and membranes weigh about half a pound, exclusive of the liquor amnii. The foetus is now so vigorous in its action, that there have been instances, though most rare, of its continuing to live, if born at so premature a period. In the seventh month, it has gained about three in-



ches in length, and is now more able to live independent of the uterus; though even at this time, the chance of its surviving six hours from birth is much against it. In the eighth month, it measures about fifteen inches, and weighs four, or sometimes five pounds, whilst the involucra weighs scarcely one. These calculations vary according to the sex of the child, and also the conformation of the parents. Male children generally weigh more than females. Dr Roederer\* concludes, from his examinations, that the average length of a male, at the full time, is twenty inches and a third, whilst that of a female is nineteen inches and seventeen eighteenths. Dr Joseph Clarke has given a table of the comparative weight of male and female children at the full time, from which it appears, that although the greatest proportion of both sexes weigh seven pounds, yet there are more females than males found below, and more males than females above that standard. Thus, whilst out of sixty males, and sixty females, thirty-two of the former, and twenty-five of the latter, weighed seven pounds, there were fourteen females, but only six males, who weighed six pounds. On the other hand, there were sixteen males, but only eight females, who weighed eight pounds. Taking the average weight of both sexes, it will be found, that twelve males are as heavy as thirteen females. The placenta of a male, weighs, at an average, one pound two ounces and a half, whilst that of a female weighs half an ounce less. Female children, who, at the full time, weigh under five pounds, rarely live; and few males, who even weigh five pounds, thrive. They are generally feeble in their actions, and die in a short time.

When there are two children in utero, the weight of each individual is generally less than that of the fœtus who has no companion; but their united weight is greater. When a woman has twins, it either usually happens, that both children are small, or one is of a moderate size, and the other is diminutive; though I have known instances; where both the children were rather above, than under the usual stand-

\* Comment. Götting. 1753.

ard. The average weight of twelve twins, examined by Dr Clarke, was eleven pounds the pair, or five and a half each. Twins require more pabulum from the mother, and a greater degree of action in the uterus; for two placentæ must have their functions supported. The uterus is also generally more distended, and produces greater irritation; it has more blood circulating in it; and the weight of its contents, to that with a single child, has been stated as twenty to fifteen. Twin gestation often produces a greater effect on the system, making the women more disposed to disease, and less able to bear it: hence the chance of recovery has been supposed to be four times less in them, than in those who have single children. The children, being generally feebler than when only one is contained in the uterus, are more disposed to disease; and, as the mother is less able to suckle children after a twin labour, many perish, who might have been preserved, by providing a good and careful nurse, soon after birth, for the weakest child.

When the number of children increases above two, the aggregate weight does not increase. Thus Dr Hull of Manchester met with a delivery of five children, who did not weigh two pounds and a quarter; they measured from eight to nine inches in length, and two of them were born alive.

Calculations have been made of the proportion of single births, to those where there were a plurality of children. In the Dublin hospital, one woman in fifty-eight had twins. In the British lying-in hospital, one in nine-one. In the Westminster hospital, one in eighty. In my own practice, about one in ninety-five. In the Dublin hospital, triplets have not occurred above once in five thousand and fifty times. More than three are not met with, once in twenty-thousand times.

The proportion of male children, born in single births, is greater than of females. In an extensive parish in this place, the number of males, born in a given time, was to that of females, as 3716 to 3177. In the Westminster hospital, it was as 972 to 951; but in the same hospital, it is worthy of

remark, that the number of male twins was only 16, whilst that of females was 30.

#### SECTION SEVENTH.

The foetus has many peculiarities which distinguish it from the adult, and which are lost after birth, or gradually removed during gestation. In particular, the liver is of great size, by which the abdomen is rendered more prominent than the thorax. It appears very early, and increases rapidly till the fourth month, after which its growth is slower. In the child, after birth, the greatest quantity of blood in the liver is venous, and from this the bile seems to be secreted. But in the foetus, the blood is more nearly approaching in its nature to arterial; and no bile, but a fluid different in its properties, is secreted. The gall bladder is filled with a green fluid, which, before birth, becomes darker, with a tinge of blue, but is said not to have a bitter taste. The umbilical vein, which contains blood, changed in the placenta, enters the liver, and sends large branches to the left side; the vena portæ enters the liver, and ramifies on the right side; whilst a branch, or canal of communication, is sent from the umbilical vein to the vena portæ. By this contrivance, the left side is supplied altogether with pure blood from the placenta, and the right side is supplied with a mixture of pure and impure blood, which does not form perfect bile. After birth, as the circulation from the placenta is stopped, the branches of the umbilical vein, which supplied the left side, would be empty, did not the canal, which formerly served to carry a portion of blood from this vein to the vena portæ, now permit this latter vessel to fill the branches in the left side, which henceforth form a part of the vena portæ. The whole liver is thus supplied with blood entirely venous. Bile is formed, and sometimes in very considerable quantity.

The blood of the foetus differs from that of the adult. It forms a less solid coagulum, for, in place of fibrous matter, it yields a soft tissue, almost gelatinous. It is not rendered



florid by exposure to air\*, and it contains no phosphoric salts. But soon after the foetus has respired, the colouring matter, exposed to oxygen, acquires the vermillion tint; and salts are formed, particularly the phosphate of lime.

The stomach is smaller in the foetus, than in the child after birth. The intestines, which at first, are seen like threads arising from the stomach, are redder, and said to be longer in proportion to the body in the foetus, than in the child. They are at first uncovered, but, after some time, the abdominal muscles and integuments form a complete inclosure. They contain a soft substance like ointment, of a dark green colour, called meconium.

The testicles of the male, and the ovaria of the female, lie on the *psoæ* muscles, but, before birth, the testicles pass into the scrotum. The kidneys are large and lobulated, and the ureters thick. The *glandulæ renales* are large, and contain a reddish fluid. The bladder is more conical and lengthened out, than in the adult. The lungs are dense and firm, and a large gland, called *thymus*, is contained in the thorax. The heart is very different from its adult state. In the chick, we find that there is in the situation of the heart, a single cavity which afterwards corresponds to the left ventricle. At the forty-sixth hour, the ventricle and bulb of the aorta are visible. Then an auricle is formed by the *vena cava*: this auricle does not adhere directly to the ventricle, until the sixth day, but is connected with it till that time by a short duct, called *canalis auricularis*. In about ninety-six hours the auricle begins to exhibit marks of a division into two cavities, or a right and a left side; and some time afterwards, the right ventricle and lungs are evolved. The structure of the heart, however, is still different from that which obtains after birth; for though the auricles are divided into two cavities, yet these are seen, in the human foetus, to communicate freely by a vacancy in the septum; and even after this is supplied, it is only with a valve, which allows the blood to pass from the right to the left side. This is the *foramen ovale*, which is shut up after birth. Another

\* Bichat made experiments, to ascertain this upon guinea pigs, and always found the foetal blood black. *Anatomic Generale*, Tome II. p. 343.

peculiarity of the foetal heart is, that the pulmonary artery, although it divide into two branches for the lungs, yet sends a third, and still larger branch, directly into the aorta, just at its curvature, and this is the ductus arteriosus. The blood is received in a purified state from the placenta, by the umbilical vein, which, after giving off branches in the liver, sends forward the continuation of the trunk, to terminate in the vena cava, or largest of the hepatic veins, and this continuation is named ductus venosus. The mixed blood which is thus found in the vena cava, is carried to the right auricle, and thence to the corresponding ventricle. By the pulmonary artery it ought to be conveyed to the lungs, but this would be useless in the foetus, and therefore the greatest part of it passes on by the ductus arteriosus to the aorta. But it follows from this, that as little blood is carried to the lungs, so little can be brought from them by the pulmonary veins to the left auricle. Now, to obviate this, and fill that auricle at the same time with the right, the foramen ovale is formed; and thus, as the blood can pass freely from the right to the left, the two auricles are to be considered as one cavity, being filled and emptied at the same time.

The aorta is distributed to the different parts of the body; but this singularity prevails, that the hypogastric vessels run up all the way to the navel, and pass out to form the umbilical arteries. After birth, these arteries are obliterated in their course to the navel; and the foramen ovale, and ductus arteriosus become impervious.

The head of the foetus is, at first, membranous, and the brain a pulp, soluble in aqua kali puri. By degrees, distinct cartilaginous plates are formed over the brain, which are gradually converted into bones. These, at birth, are only united by intermediate membranes.

The pupil of the eye, till the seventh month, is shut up by a membrane; and the eye-lids, for some months, adhere together.

The skin is covered with a white substance, which, though unctuous to the feel, does not melt, but dries and crackles by heat. It is miscible with spirits, or with water, through the medium of soap or of oil.

The male fœtus differs from the female, in having the head larger, but less rounded, and flatter at the back part. The thorax is longer, and more prominent, and formed of stronger ribs than in the female. In her, it is wider from the upper part to the fourth rib, and narrower below; the belly, also, in the female, is more prominent, and the symphysis pubis projects more. The upper extremities are shorter than those in the male; the thighs are thicker at the top, and more tapering to the knees. Dr Soemmerring says, that the spinous processes of the lower dorsal, and upper lumbar vertebræ, make in the male an eminence like a yoke, in the female a sinuosity. I may remark, that as the clitoris is large in the young fœtus, females sometimes pass in abortions for males.

When in utero, the fœtus assumes that posture which occupies least room. The trunk is bent a little forward, the chin is pushed down on the breast, the knees are drawn up close to the belly, and the legs are laid along the back part of the thighs, with the feet crossing each other. The arms are thrown into the vacant space betwixt the head and knees. This is the general position, and the child thus forms an oval figure, of which the head makes one end, and the breech the other. One side of it is formed by the spine and back part of the head and neck, and the other by the face and contracted extremities. The long axis of this ellipse measures, at the full time, about ten inches, and the short one five or six. In the eighth month, the long axis measures about eight inches. In the sixth, betwixt four and five. In the fourth month, it measures nearly three inches and a half: and in the third, about an inch less. In the early months, however, there is no regular oval formed, and these measurements are taken from the head to the breech, which afterwards form the ends of the distinct ellipse. The extremities are at first small and slender, and bend loosely toward the trunk.

#### SECTION EIGHTH.

The umbilical cord is an essential part of the ovum, con-



necting the foetus to its involucra. It is found in oviparous and viviparous animals, and also in plants; but in these different classes, it appears with many modifications. In the human subject, it consists of three vessels; of which two are arteries, and one is a vein. These are imbedded in gluten, and covered with a double membranous coat. The two arteries are continuations of the arteriæ hypogastricæ of the child, and passing out at the navel, run in distinct and unconnected trunks, until they reach the placenta, where they ramify and dip down into its substance. When they reach the placenta, the one artery, in some cases, sends across a branch to communicate with the other. The vein commences in the substance of the placenta, forms numerous rays on its surface, corresponding to the branches of the arteries; and near the spot where the arteries begin to give off branches, these rays unite into a single trunk, the area of which is rather more than that of the two arterics. None of these vessels are furnished with valves.

The umbilical vessels run in a spiral direction, within the covering of the cord, and the twist is generally from right to left. Besides this twisting, we also find, that the vessels, especially the arteries, form very frequently coils, loosely lodged in the gluten.

The cord does not consist entirely of vessels, but partly of a tenacious transparent gluten, which is contained in a cellular structure; and these numerous cells, together with the vessels, are covered with a sheath, formed by the reflection of both chorion and amnion from the placenta, and of necessity, the amnion forms the outer coat of the cord. The chorion adheres firmly to the cord every where, but the amnion does not adhere to the chorion; it is not even in contact with it at the placental extremity, but forms there a slight expansion, which, from its shape, has been called by Albinus, the processus infundibuliformis.

The proportion of gluten is larger in the early than in the advanced stage of gestation; and the vessels, at first, run through it in straight lines. In some instances, the cells dis-

tend or augment in number, so as to form tumors on the cord, which hang from it like a dog's ear.

There is a small sac, or bladder, found on the placenta, at or near the extremity of the cord, in the early part of gestation. It is most distinct betwixt the third and fourth month of pregnancy, and is placed exterior to the amnion. It is filled, though not quite distended, with a whitish fluid, on which account, it is called the *vesicula alba* \*. From this, a very fine vessel proceeds along the cord, adhering firmly to the amnion; but, without a glass, it cannot be traced all the way to the navel. It has been supposed to be subservient to the nourishment of the fœtus in its early stage. A small artery and vein pass along the cord from the navel, to the vesicle which is between the chorion and amnion. These are the omphalo-mesenteric vessels.

Besides the blood vessels, there is in brutes another vessel, which is a continuation of the fundus vesicæ. It passes out at the navel, and, running along the cord, terminates in a bag, which is placed betwixt the chorion and amnion. The bag is called the allantois, and the duct the urachus. In the human subject, in place of the urachus, we find only a small white impervious cord. There is of course no allantois.

When the ovum is first visible in the uterus, there is no cord, the embryo adhering directly to the involucre, but it soon recedes; and about the sixth week, a cord of communication is perceptible.

The cord at the full time varies in length, from six inches† to four feet‡; but its usual length is two feet. When it is too long, it is often twisted round the neck or body of the child, or occasionally has knots formed on it, || most frequently, perhaps, by the child passing through a coil of it during labour §.

\* Vide Albinus, Annot. Acad. lib. I. cap. xix. p. 74. et tab. I. fig. 12.

† Hildanus, cent. II. obs. 50.

‡ Mauriceau has seen it a Paris ell and a third, obs. 401.—Hebenstreit 40 inches.—Haller Disp. Anat. Tom. V. p. 675.—Wrisberg 48 inches—Vide Com. Gotting. Tom. IV. p. 60.

|| Vide Mauriceau, obs. 133 and 156.

§ Dr Hunter thinks he has twice seen these formed, previous to birth.

The vessels of the cord sometimes become varicose, and form very considerable tumors. These, occasionally, so far impede the circulation, as to interfere with the growth of the child, or even to destroy it altogether. Sometimes the vessels burst, and blood is poured into the uterus, which produces a feeling of distension, and excites pain. There can however, be no certainty of this accident having taken place until the membranes burst, when clots of blood are discharged. If the foetal and maternal vessels should communicate, the mother is weakened, and may even faint; and, in every instance, the child suffers, but does not always die\*. Delivery must be resorted to, either on account of the effects produced on the mother, or to prevent the destruction of the child.

The cord may by a fall, or violent concussion of the body, be torn at a very early period of gestation. In this case, the child dies, but is not always immediately expelled. It may be retained for several weeks; afterwards the ovum is thrown off, like a confused mass, inclosing a foetus, corresponding in size to the period when the accident happened†. The cord may be filled with hydatids.

The cord has been found unusually small and delicate, or, on the contrary, very thick. In the latter case, it is always proper to apply two ligatures, instead of one, on the portion which remains attached to the child‡. It has happened, that, by the shrinking of the cord under the ligature, the child has died from hemorrhage||.

Two cords have been met with, connected with one placenta, or with two placentæ belonging to one child. In other instances, the vessels are supernumerary or deficient. Stories have been told of the cord being altogether wanting, but these are incompatible with the foetal œconomy,

\* Vide Baudelocque l' Art, note to section 1084.

† Vide Case by M. Anel, in Mem. of Acad. of Sciences, 1714.

‡ This was proposed by Mauriceau, in consequence of meeting with an instance, where the child suffered much from loss of blood, obs. 256.

|| Vide Case by M. Degland, in Recueil Period. Tome V. p. 345.



## SECTION NINTH.

A placenta, or something equivalent to it, is to be found connected with the young of every living creature.

We find it requisite that a pabulum should be supplied to every animal, and that certain changes should be performed on the blood, qualifying it for supporting life. In oviparous animals, two different parts of the ovum perform these separate functions. The umbilical vessels of the chick ramify on the membrane of the albumen, and thus come in contact with the air, which is absorbed through the pores of the shell; and, by this contrivance, changes analogous to those effected by respiration, are produced on the blood. From the inner surface of the membrane of the vitellus, a nourishing flood is absorbed which is conveyed to the intestine by a proper duct; and, before the chick is hatched, the remainder of this fluid, inclosed in the membrane of the vitellus, is taken within the abdomen, and covered with the abdominal integuments<sup>1</sup>.

In many quadrupeds we find, that, after impregnation, certain portions of the inner surface of the uterus enlarge, and form protuberances, having many hollows or foramina, from which a milky fluid can be squeezed. From the chorion, corresponding vascular efflorescences arise, which shoot into these apertures; and thus an union is effected betwixt the mother and fœtus.

In the sow and the mare there is no projection from the uterus, but its surface is every where smooth and vascular. There is no efflorescence from the chorion, but it has numerous vessels disposed over it, which are the extremities of the umbilical arteries and veins. In these animals, then, we have no distinct placenta, the chorion alone serving that purpose.

The cetaceæ have uteri like quadrupeds, but I am unacquainted with the precise mode of connection betwixt the mother and the fœtus.

The monkey differs from other quadrupeds, in having no

permanent papillæ; but the maternal part of the placenta is deciduous, like that of women.

In the human subject, the placenta is a flat circular substance, about a span in diameter, and, when uninjected, an inch in thickness. It becomes gradually thinner from the centre to the circumference, by which it ends less abruptly in the membranes. Its common shape is circular; but it is sometimes oblong, or divided into different portions.

The umbilical cord may be fixed into any part of the placenta, or sometimes into the membranes, at a distance from the placenta. When this happens, the vessels run in distinct branches to the placenta, without forming any spongy substance on the membranes. Most frequently, however, the cord is inserted at a point about half way between the centre and the circumference of the placenta. From this the umbilical vessels spread out, like a fan, ramifying over the surface, and dipping their extremities into the substance of the placenta itself.

That surface of the placenta which is attached to the uterus, is divided into lobes, with slight sulci between them, and is covered with a layer of the decidua, like clotted blood. On the surface which is next the child, we see the eminent branches of the umbilical vessels, over which we find spread the chorion and amnion.

If we inject, from the umbilical vessels of the human fœtus, we find that the placenta is rendered turgid, and vessels are to be found filled in every part of it; but always between their ramifications, there remains an uninjected substance. even the uterine surface of the placenta is not injected, for the fœtal vessels do not pass all the way to that surface.

If we inject from the uterine arteries, we, in like manner, render the placenta turgid, but nothing passes into the umbilical vessels; and, when we cut into the placenta, we find cells full of injection, and covered with a fibrous uninjected matter. Hence we may infer, that the placenta consists uniformly of two portions. The one is furnished by the deciduous coat of the uterus, the other by the vessels of the chorion; and these two portions may, during the first

three months, be separated, by maceration, from each other.

The structure of the foetal portion, so far as we know, appears to be similar to that of the pulmonary vessels, the artery terminating in the vein. But the other portion is somewhat different: there is not a direct anastomosis, but the artery opens into a cell, and the vein begins from this cell; for, by throwing in wax by the uterine artery, we may frequently inject the veins. These cells communicate freely with each other in every part of the placenta, and may be compared to the corpora cavernosa penis.

From the general principles of physiology, as well as from experiments on the chick in ovo, and from the fatal effects which instantly follow compression of the cord whilst the child is in utero, it is allowable to infer, that the placenta serves to produce a change on the blood of the foetus, analogous to that which the blood of the adult undergoes in the lungs; and from considering, that the foetus itself cannot create materials for its own growth and support, we may farther infer, that the placenta is the source of nutrition also.

The placenta may be formed at any part of the uterus, but, in general, it is found attached near the fundus.

Its structure is sometimes changed, part of it being ossified or indurated, or on the contrary unusually soft. These changes may produce either hemorrhage, or retention of the placenta. Hydatids may form in the placenta; or fleshy tumors may grow in its substance. In neither of these cases does the child necessarily die.

#### SECTION TENTH.

The ovum, when it descends into the uterus, consists of two membranes, one within the other. These inclose the embryo, and contain a quantity of fluid.

The innermost membrane, or amnion, is thin, pellucid, and totally without the appearance of either vessels or regular fibres; yet, in the end of pregnancy, it is stronger than all the rest taken together: it lines the chorion, covers the placenta, and mounts up on the navel string, affording



a coat to it all the way to the umbilicus, where it terminates.

The *sae*, formed by the amnion, is filled with a fluid, which appears to be composed chiefly of water, with a very little earth, mucus, and saline matter. As this water is contained within the amnion, it has received the name of liquor amnii.

The quantity of water, upon an average, which is contained within the amnion, at the full time, is about two English pints; but sometimes it is much more, and at other times scarcely six ounces. In the early periods, the quantity is larger, in proportion to the size of the uterus, than afterwards.

The chorion, like the amnion, is thin and transparent, adheres firmly to the placenta, and covers all the vessels which run on its surface; but it does not dip down with them into the substance of the placenta. When the ovum first descends, the chorion is every where covered with vessels, which sprout out from it. These form a covering to it, which, from its appearance, has been called the shaggy, or spongy chorion.

#### SECTION ELEVENTH.

The last coat to be described, is one yielded entirely by the uterus, and serves to connect the uterus with the foetal vessels of the chorion together. This, as Harvey observes, is not a covering of the foetus, but a lining of the uterus, which falls off after delivery; and therefore it is called the caducous coat, or the *membrana decidua*.

The illustrious Haller supposed, that this was formed by naked vessels shooting out from the uterus. Dr Hunter imagined, that the arteries of the uterus poured out coagulable lymph, which was afterwards changed into decidua. His brother, Mr John Hunter, attributed its origin to coagulated blood, which formed a pulpy substance on the inner surface of the uterus.

Having been so fortunate as to meet with three or four opportunities of investigating the state of the uterus, within

a month after conception, I shall describe what appears to me to be the structure of the decidua. Very speedily after impregnation, and always before the embryo enters into the womb, its size is increased, its fibres are softer and more separated from each other, and its vessels very much enlarged. On cutting it up, its cavity is found to be considerably broader and longer, and somewhat wider than in the unimpregnated state; and all the fundus and body have their surface covered with a dense coat, which adheres firmly to the uterus. If the vessels have been injected, this evidently is seen to consist of two different substances, namely vessels, and a firm tough gelatine. It seldom happens that all the vessels can be equally filled, and therefore some spots are redder than others. The vessels do not pass on to the surface of this coat, but are seen shining through it. They proceed directly from the surface of the womb, and project at right angles to the plane which yields them; they are intermixed with a little gelatine, and consist of both arteries and veins. Over their extremities is spread a layer of gelatinous matter, which very early is observed to contain fibres, forming a kind of net-work. Thus the decidua consists of two layers, one highly vascular, proceeding directly from the uterus; the other, which is most probably formed by these vessels, is more fibrous and gelatinous; and when this is removed, the primary vessels, or outer layer, may be seen like a fine efflorescence, covering the surface of the uterus. In some cases the decidua extends a little into the fallopian tubes; in other instances it does not. In no case does the cervix form decidua. It is only produced by the fundus and body of the womb; and immediately above the cervix, the decidua stretches across, so as to form a circumscribed bag within the uterus. In some instances, however, I have observed this continuation to be wanting, although the parts were opened with care. In all other circumstances, these uteri resembled those where the decidua was continued across; but, perhaps, notwithstanding this, there may have been a difference of two or three days in the period of impregnation, occasioning this variation. In every case, the

decidua, consisting thus of two layers, is completely formed before the ovum descends.

When the embryo passes down through the tube, it is stopped, when it reaches the uterus, by the inner layer, which goes across the aperture of the tube, and thus would be prevented from falling into the cavity of the uterus, even were it quite loose and unattached. By the growth of the embryo, and the enlargement of the membranes, this layer is distended, and made to encroach upon the cavity of the uterus, or more correctly speaking, it grows with the ovum. This distention or growth gradually increases, until at last the whole of the cavity of the uterus is filled up, and the protruded portion of the inner layer of the decidua comes in contact with that portion of itself which remains attached to the outer layer. We find then, that the inner layer is turned down and covers the chorion; from which circumstances, it has been called the reflected decidua.

Thus we see, that whenever the ovum descends, it is encircled by a vascular covering from the uterus, which unites, in every point, with those shaggy vessels which sprouted from the chorion, and which made what was called the spongy chorion. One part of these vessels forms placenta, and the rest gradually disappear, leaving the chorion covered by the decidua reflexa. This obliteration begins first at the under part of the chorion.

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## CHAP. XVI.

### *Of Sterility,*

STERILITY depends either on malformation, or imperfect action of the organs of generation. In some instances the ovaria are wanting, or too small; or the tubes are imperforated; or the uterus very small. In these cases the menses generally do not appear, the breasts are flat, the external organs small, or they partake of the male structure, and the sexual desire is inconsiderable.

In a great majority of instances, however, the organs of generation seem to be well formed, but their action is



imperfect or disordered. The menses are either obstructed or sparing, or they are profuse or too frequent, and the causes of these morbid conditions have been already noticed.

It is extremely rare for a woman to conceive, who does not menstruate regularly; and on the contrary, correct menstruation generally indicates a capability of impregnation on the part of the woman.

A state of weakness and exhaustion of the uterine system occasioned by frequent and promiscuous intercourse with the other sex, is another very common cause of barrenness in women, and hence few prostitutes conceive.

A morbid state of the uterus and ovaria, often accompanied with fluor albus, may likewise be ranked amongst the causes of sterility, and this is known by its proper characters.

When sterility depends upon organic disease, we have it seldom in our power to remove it; but when there is no mark of the existence of such a state, and we have ground to suppose that it is occasioned by debility, or imperfect action of the uterine system, we are to employ such means as have been pointed out in considering the diseased states of menstruation. In many cases, much success attends the tonic plan of treatment, particularly the use of the cold bath, and chalybeate medicines. A temporary separation from the husband is of service, especially when the menses are profuse, and, in most cases, frequent intercourse should be avoided.

Women who are very corpulent, are often barren, for their corpulence either depends upon want of activity of the ovaria; spayed, or castrated animals generally becoming fat: or it exists as a mark of weakness of the system. In both cases, moderate exercise, and chalybeate water or nitrous acid, may be of service, but it must be confessed, often fail. These remarks are also applicable to women who are of a spare, delicate habit. Should a woman, who has been for some years barren, conceive, she must be very careful during gestation, for abortion is readily excited.

In some cases, the uterine system is capable of being acted on by the semen of one person, but not of another.

## CHAP. XVII.

*Of Extra-uterine Pregnancy.*

## SECTION FIRST.

It sometimes happens, that the ovum does not pass down into the womb, but is retained in the ovarium, or stops in the tube, or is deposited among the bowels. Of all these species of extra-uterine pregnancy, the tubal is the most frequent.

The symptoms of extra-uterine pregnancy are not, at first, very definite; but generally the usual sympathetic effects of pregnancy, or the diseases of gestation, are more distressing than if the foetus were contained in utero, nor do they cease so early. In some cases, they even increase in violence, as pregnancy advances.\*

The symptoms, though often more violent, are, however, similar in kind, to those of common pregnancy. The belly swells, the uterus itself enlarges, and may be felt to be heavy; but, after some time, it does not correspond in its size, and in the state of its cervix, to the supposed period of gestation. The menses are often obstructed, though in some cases they have continued to appear for two or three months. The breasts enlarge, the morning sickness takes place about the usual period<sup>1</sup>, and the child quickens at the proper time, but it is felt chiefly upon one side.

Occasionally in the early stage of pregnancy, pains<sup>2</sup> resembling those of colic are felt, and these are often so severe as to excite syncope<sup>3</sup>, or convulsions<sup>†</sup>; and it has happened, that during these pains, the tube or ovarium has burst, and the person died, owing to the internal hemorrhage. When these pains either do not occur, or are removed, we generally find, that at the end of eight, nine, or ten months from the commencement of gestation, appearances of labour<sup>4</sup> take place; the woman suffers much from pain, and there

\* Vide Paper by Dr Garthshore, Lond. Med. Journ. Vol. VIII. p. 344.

† Vide Dr Ferri's case, and a case by Mr Jacob, in Lond. Med. Jour. Vol. VII. p. 147.

may be a sanguinous discharge from the uterus. The pains go off more or less gradually \*, the motion of the child ceases, and milk is secreted †. In a few instances, very little farther inconvenience is felt, the tumor of the belly remaining for many years, and the child being converted into a substance resembling the *gras des cimetières*, whilst the sac which contains it becomes indurated. More frequently, however, considerable irritation is produced ‡, inflammatory symptoms supervene, and hectic takes place. The sac adheres to the peritoneum, or intestines; and after an uncertain period, varying from a few weeks or months to several years, it either opens externally, or communicates with the abdominal viscera. Very foetid matter, together with putrid flesh, bones, and coagula, are discharged through the abdominal integuments †, or by the rectum<sup>5</sup>, vagina<sup>6</sup>, or bladder<sup>7</sup>. Sometimes, even an entire foetus has been brought away from the umbilicus<sup>8</sup>, or by the rectum<sup>9</sup>. It is worthy of notice, that the placenta, in this process, always is ultimately destroyed<sup>10</sup>, and discharged among the putrid fluid. Often, time is not allowed for this process to be accomplished, but the person dies at an early period.

Thus it appears, that there are different terminations of the extra-uterine pregnancy. The sac may burst, and the person die speedily of hemorrhage<sup>11</sup>; or the child may escape into the abdomen, and be inclosed in a kind of cyst of lymph ||; or the sac may remain entire, the child being retained many years<sup>12</sup>, and the parts become hard; notwithstanding this, the menses may return, and the woman conceive again<sup>13</sup>. But the most frequent termination is that of inflammation ending in abscess, attended with fever and pain, under which the patient either sinks, or the foetus is expelled in pieces, and the cure is slowly accomplished. From a review of cases it appears, that a majority ultimately recover, or get the better of the immediate injury: of the

\* In Mr Bell's case, the pains continued, though gradually abating, for three weeks. Med. Comment, Vol. II. p. 72.

† In Mr Bell's case, milk continued to be secreted for several years. In Mr Turnbull's case, a fluid was secreted, rather like pus than milk.

‡ This termination is noticed so long ago as by Albucasis, lib. II. c. 76.

§ Vide a case by La Croix, in La Med. Lécuree, Tome, IV. p. 349.



rest, some have sunk speedily, either from hæmorrhage or inflammation, or exhaustion produced by ineffectual attempts to expel the child; or more slowly from hectic fever; or in consequence of some other disease being called into action, by the violence which the constitution has sustained.

In some cases, the sac rises quite out of the pelvis. In others, it falls down between the rectum and vagina, forming a tumor, accompanied with symptoms of retroversion<sup>14</sup> of the uterus; but the urine is not so constantly suppressed, and the os uteri, though pressed to the symphysis, is not so much turned up as in retroversion \*. In such cases, the sac inflames, and bursts into the rectum or vagina.

Sometimes, when parturient efforts are made, the head descends into the pelvis, though it was not there before; but either no os uteri can be felt, or it is felt directed to the pubis, and it is not affected by the pains.

It is curious to observe, that generally the uterus enlarges somewhat<sup>15</sup>, and in most instances, I imagine, decidua<sup>16</sup> is formed. In a remarkable case, related by the ingenious Mr Hey † of Leeds, the placenta was formed in the uterus, while the foetus lay in the tube.

Tubal pregnancy sometimes does not proceed farther than the second month, the tube bursting at that time; or, to speak more correctly, I believe the tube slowly inflames, and sloughing takes place. In a great majority of instances, however, the tube goes on enlarging for nine months, and acquires a size nearly equal to that of the gravid uterus, at the same stage of gestation ‡. The placenta differs from a uterine placenta, in being much thinner and more extended. External examination discovers little difference, at the full time, between this and common pregnancy.

Ovarian<sup>17</sup> is much more rare than tubal pregnancy, and it is seldom that the ovarium acquires a great size. It either bursts early<sup>18</sup>, or inflammation and abscess take place; or the

\* Vide Mr Mainwarring's case, in Trans. of a Society, &c. Vol. II. p. 287.

† Vide Med. Obs. and Inq. Vol. III. p. 341.

‡ Among many other cases, in proof of this, I may refer to one very accurately detailed by Dr Clarke, in the Trans. of a Society, &c. Vol. II. p. 1.

foetus dies, and is converted into a confused mass; or it excites dropsy of the ovarium<sup>19</sup>. The ovarian pregnancy, until inflammation has taken place, produces a circumscribed moveable tumor, like dropsy of the ovarium.

In ventral pregnancy, the most rare of the three species, the motions of the child are felt more freely, and its shape is readily distinguished through the abdominal integuments. The expulsive efforts come on as usual, and the head of the child is sometimes forced into the pelvis. It dies, and the usual process for its removal is carried on, if the woman do not sink immediately under the irritation. The placenta is found attached to the mesentery or intestines<sup>20</sup>.

#### SECTION SECOND.

In the treatment of extra-uterine pregnancy, much must depend on the circumstances of the case. In the early stage, if the sac be lodged in the pelvis, we must procure stools, and have the bladder regularly emptied, as in cases of retroverted uterus. Attacks of pain, during the enlargement of the tube, require blood-letting and anodynes, laxatives and fomentations. The same remedies are indicated when convulsions take place. Ovarian requires a similar management with tubal pregnancy, except that if it be complicated with dropsy, relief may be obtained by tapping.

When expulsive efforts are made, and the head is felt through the vagina, and the nature of the case distinctly ascertained, it may be supposed, that much suffering may be avoided, by making an incision through the vagina, and delivering the child; but, as yet, experience has not fully ascertained the utility of this practice \*. It has been proposed, in these and other circumstances, to perform the cæsarean operation †, in the usual manner, upon the accession of labour; but there is not only great danger from the wound,

\* In a case, probably of this kind, related by Lauerjat, and quoted by Sabatier, the child was extracted by an incision through the vagina, and the woman recovered. *De la Med. Operet.* Tome I. p. 136.

† M. Colomb performed the cæsarean operation, but it ended fatally. *Recueil des Actes de la Société de Lyon.*

but likewise from the management of the placenta, which if removed, may cause hemorrhage, especially in ventral pregnancy, and, if left behind, may produce bad effects. The last, however, is the safest alternative.

The result of the numerous cases upon record, will certainly justify, to the fullest extent, our trusting to the powers of nature, rather than to the knife of the surgeon. Allaying pain and irritation in the first instance, by blood-letting, anodynes, and fomentations; and avoiding, during all the inflammatory stage, stimulants and motion, whilst, by suitable means, we palliate any particular symptom, constitute the sum of our practice.

A tendency to suppuration is to be encouraged by poultices; and the tumor, when it points externally, is either to be opened, or to be left to burst spontaneously, according to the sufferings of the patient, and the exigencies of the case<sup>21</sup>. The passage of the bones, and different parts of the fœtus, may often be assisted; and the strength is to be supported under the hectic which accompanies the process. After the abscess closes, great care is still necessary, for, by fatigue or exertion, it may be renewed, and prove fatal<sup>22</sup>.

When no process is begun for removing the fœtus, but it is retained and indurated, our practice is confined to the palliation of such particular symptoms as occur.

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## CHAP. XVIII.

### *Of the signs of pregnancy.*

SOME women feel, immediately after conception, a particular sensation, which apprizes them of their situation; but such instances are not frequent; and, generally, the first circumstances which lead a woman to suppose herself pregnant, are the suppression of the menses, and an irritable, or dyspeptic state of the stomach. She is sick or vomits in the morning, and has returning qualms or fits of languor during the forenoon; is liable to heartburn through the day or in the evening, and to that disturbed sleep through the night, which so frequently attends abdominal irritation. In some



instances; the mind also is affected, becoming unusually irritable, changeable, or melancholy. The breasts often at first become smaller, but about the third month they enlarge, and occasionally become painful; the nipple is surrounded with a brown circle or areola; and often, even at an early period, a serous fluid begins to ooze from it. The woman loses her looks, becomes paler, and the under part of the lower eye-lid is of a leaden hue. The features become sharper, and sometimes the whole body begins to be emaciated, whilst the pulse quickens. In many instances, particular sympathies take place, causing salivation, tooth-ach, jaundice, &c. In other cases, very little disturbance is produced, and the woman is not certain of her condition, until the child quickens, which happens about the fourth or fifth month of pregnancy; in a few instances, at the end of the third. This quickening is attended with a sensation of motion, or fluttering in the lower belly, and is not unfrequently accompanied with faintishness or hysterical irritation. Such affections, however, do not usually last long, and the morning sickness also generally abates after this period, and the mind becomes more equable, whilst the corporeal system is also improved.

In the commencement of pregnancy, the abdomen does not become tumid, but, on the contrary, is often rather flatter than formerly; and, when it does first increase in size, it is rather from inflation of the bowels, than from expansion of the uterus. As an increase of bulk, together with many of the other symptoms of gestation, may proceed from suppression of the menses, we cannot positively, from those signs, pronounce a woman to be with child. The enlargement of the belly is at first accompanied with tension or uneasiness about the navel.

When women have any doubt, with regard to their situation, they generally look forward to the end of the fourth month, as a period which can ascertain their condition. For, at this time, or a little sooner or later, in different women, the motion of the child is first perceived, or it is

said to quicken ; and, in some cases, a few drops of blood flow from the uterus at this period. The motion is first felt in the hypogastrium, and is languid and indistinct, but by degrees it becomes stronger. It is possible for women to mistake the effects of wind for the motion of a child, especially if they have never born children, and be anxious for a family. But the sensation produced by wind in the bowels is not confined to one spot, but very often is referred to a part of the abdomen, where the motion of the child could not possibly be felt.

Many women suppose, that, by examining the blood drawn from the veins, their pregnancy may be ascertained. Very soon after impregnation, the blood becomes sizzly ; but it differs from the blood of a person affected with inflammation. In the latter case, the surface of the crassamentum is dense, firm, and of a buff colour, and more or less depressed in the centre. But in pregnancy the surface is not depressed, the coagulum is of a softer texture, of a yellow, and more oily appearance. It is not possible, however, to determine positively, from inspecting the blood ; for a pregnant woman may have some local disease, giving the blood a truly inflammatory appearance ; and, on the other hand, it is possible for suppression of the menses, accompanied with a febrile state, to give the blood the appearance which it has in pregnancy.

Examination of the uterus itself is a more certain mode of ascertaining pregnancy. About the second month of gestation, the uterus may be felt prolapsing lower in the vagina than formerly ; its mouth is not directed so much forward as before impregnation ; it is shut up, and the cervix is felt to be thicker, or increased in circumference. When raised on the finger, it is found to be heavier, or more resisting. Some have advised, that the os uteri should be raised upward and forward, so as to retrovert the womb, in order that its body may be felt, but this is not expedient. Examination, at this period, is liable to uncertainty, because the uterus of one woman is naturally different in magnitude from that of another. But in the third month we can arrive at tolerable

certainly, the womb being then felt decidedly to be heavier, and more easily balanced on the finger. In the fourth month it is found to be higher than when unimpregnated: a kind of fluctuation may be perceived, and by placing the hand on the lower part of the belly, so as to press on the fundus of the womb, it can be made to give more resistance to the finger applied per vaginam, and may by it be rolled about. After quickening; if we pat with the finger on the cervix uteri, we can generally make the child strike gently, so as to be felt. About this time, and still more distinctly afterwards, we can, if the abdominal muscles be relaxed, feel the uterus extending up from the symphysis pubis, and, in proportion as pregnancy advances, can more readily distinguish the members of the child, and feel its jerks or motions. Examination, per vaginam, informs us of those changes of the cervix and os uteri, which were noticed in a former chapter.

## CHAP. XIX.

### *Of the Diseases of Pregnant Women.*

#### SECTION FIRST.

PREGNANCY produces an effect on the general system, marked often by a degree of fever, and always by an altered state of the blood. This state is the consequence of local increased action, which irritates and excites the system, in the same way as when an organ is inflamed. There would appear to be, likewise, a tendency to the formation of more blood than formerly; and the nervous system is evidently rendered more irritable. The gravid uterus, also, has an effect by sympathy, on other organs or viscera; and likewise produces changes in them, mechanically, by its bulk and pressure. All these effects, however, vary much in degree in different women.

The effects of pregnancy vary much, both in degree, and in the nature and combination of the symptoms, according to the constitution of the woman, and the natural or acquired



irritability of different organs. In a few cases, a very salutary change is produced on the whole system, so that the person enjoys better health during pregnancy, than at other times. But in most instances, some troublesome or inconvenient symptoms are excited, which are called the diseases of pregnancy, and which in some women, proceed so far, as not only to deprive them of all enjoyment and comfort, but even to produce considerable fear of their safety.

As these proceed from the state of the uterus, it follows, that when they exist in a moderate degree, they neither admit of, nor require any attempts to cure them; for their removal implies a stoppage of the action of gestation, which is their cause. But when any of the effects are carried to a troublesome extent, then we are applied to, and may palliate, though we cannot take them away. This palliation we procure by lessening plethora, if necessary, by blood-letting, and allaying the increased irritability of the system by the regular use of laxatives. These remove that particular state of the bowels, which is so apt to cause restlessness and nervous irritation. If these are not altogether successful, the camphorated julap, is a useful medicine.\* Besides this general plan, we must diminish the febrile state of the system, where such exists, by regulation of the diet, and suitable remedies. Individual symptoms must be treated on general principles.

There is a great diversity, both in the effects of pregnancy, and also in the period at which these manifest themselves; for whilst some begin to suffer very early from the irritation of the uterus, and are much relieved from the effects thereof after the child quickens, others feel very little inconvenience till towards the end of pregnancy, or the last quarter, when the womb is greatly enlarged, and the abdominal viscera disturbed.

\* Petit, and many after him, have been of opinion, that opium is hurtful during gestation; and there can be no doubt that it generally is so when given frequently. It is detrimental, both by its effects upon the stomach and bowels, and on the system at large. In severe spasms, or great irritation, it may be necessary, but it never ought to be often repeated, as it ultimately increases the irritability and injures the bowels, as it would do in chorea.

## SECTION SECOND.

In many cases, the pulse becomes somewhat quicker soon after impregnation, and the heat of the skin is at the same time a little increased, especially in the evenings. In the later months of pregnancy, the febrile symptoms in some instances are extremely troublesome; the pulse is permanently frequent, but in the evenings it is more accelerated, whilst the skin becomes hot, and the woman restless; she cannot sleep, but tosses about till day-break, when she procures short unrefreshing slumber, occasionally accompanied with a partial perspiration. In the morning, the febrile symptoms are found to have subsided; but in the afternoon they return, and the following night is spent alike uncomfortably.

This state is attended with more emaciation, and greater sharpness of the features; than is met with in pregnancy, under different circumstances; but it is wonderful how well the strength is kept up in spite of the want of rest, and of the uneasiness which is produced, from this disease being sometimes conjoined with intolerable heat about the parts of generation.

In slight degrees of this febrile state, all that is necessary is sedulously to keep the bowels open, and take away a little blood. But when it becomes urgent towards the last months of gestation, we are under the necessity of taking away blood more frequently, but not in great quantity at a time. The saline julap is of considerable service, by producing a gentle moisture, but a copious perspiration is neither necessary nor useful. The julap may either be given in repeated doses through the day, or merely one or two doses in the morning, or early part of the night according to circumstances. The bowels are to be kept open by a mild laxative, such as the aloetic pill, or rhubarb and magnesia, or cream of tartar, if the person be not much distressed with heart-burn; and in the same circumstances, the sulphuric acid is a very good internal medicine. The restlessness is best allayed by sleeping with few bed-clothes; and sometimes great relief is obtained, by dipping the hands in water, or grasping

a wet sponge. Opiates very seldom give relief, and ought not to be pushed far, as they make the woman more uncomfortable, and are supposed even to injure the child; at all events, if the occasional exhibition, on any emergency of a moderate dose of opium or hyocyamus, fail to procure comfortable sleep, no benefit is to be expected from increasing the quantity. Frequently nothing does much good, the state continuing until the woman is delivered.

There is a species of fever, which may affect women about the middle of pregnancy, and makes its attack suddenly, like a regular paroxysm of ague. It soon puts on an appearance rather of hectic, combined with hysterical symptoms. The head is generally at first pained, or the patient complains of much noise within it, sleeps little, has a loathing at food, with a foul dry tongue, and a considerable thirst, whilst the bowels are constipated. Sometimes she talks incoherently, or moans much during her slumber, and has frightful dreams: occasionally a cough, or distressing vomiting supervenes. This disease is very obstinate, and often ends in abortion; after which, if the woman do not sink speedily under the effects of the process, she begins to recover, but remains long in a chlorotic state, which if not removed, may terminate in phthisis. I strongly suspect that this disease originates from the bowels, and bears a great analogy to the infantile remitting fever. It is usually preceded by costiveness, and is sometimes apparently excited by irregularities in diet. We ought on the first attack of the cold fit to check it by warm diluents, with the saline julap. If the proper opportunity be lost, or these means fail, we must lessen irritation by detracting some blood; open the bowels freely, and afterwards prevent feculent accumulation, keep the surface moist, and palliate troublesome symptoms. If the tongue be early loaded, and the patient is sick or squeamish a very gentle emetic will be proper. The strength is to be supported. In a state of convalescence, gentle exercise and pure air are useful, but every exertion must be avoided.



## SECTION THIRD.

Vomiting is a very frequent effect of pregnancy, and occasionally begins almost immediately after conception. Generally it takes place only in the morning, immediately after getting up, and hence it has been called the morning sickness, but in a few instances, it does not come on till the afternoon. It usually continues until the period of quickening, after which it decreases or goes off, but sometimes it remains during the whole of gestation. Some women do not vomit, and have very little if any sickness; others begin, after the fourth month, to feel an irritation about the stomach and other viscera; and some remain free from inconvenience till the conclusion of pregnancy, when the distention of the womb affects the stomach. The fluid thrown up is generally glary or phlegm, and the mouth fills with water previous to vomiting; but if the vomiting be severe or repeated, bilious fluid is ejected. Generally there is no occasion to prescribe any remedies. Puzos, and others, even considered vomiting as salutary; but in some cases, it goes to a very great length, recurring whenever the woman eats, or sometimes even when she abstains from eating, and continues for days or even weeks so obstinate, that she is in danger of miscarrying\*, or of suffering from want of food. It is a general rule, in such cases, to take away early a small quantity of blood, a quantity proportioned to the vigour and fulness of the habit, and state of the pulse. Of the utility of this practice, the general testimony of practitioners, and my own observation, fully convince me. Narcotic substances, such as opium or hyocyamus, have been tried internally, either without blood-letting or subsequent to it, but uniformly with little advantage. In a few instances, a cloth wet with laudanum applied to the pit of the stomach has done good. More certain relief is obtained by mild laxatives, in small bulk, such as pills, and in every case costiveness must be avoided. The severity of the vomiting may also be great.

\* It is worthy of remark, that abortion is very seldom occasioned by this cause, though emetics are apt to produce it.

ly mitigated by effervescing draughts, or the aerated alkaline water: the last of which, if it do not check the vomiting, renders it much easier. Even cold water has been employed with advantage. A light bitter infusion is sometimes of service. Obstinate vomiting, especially if accompanied with pain, or tension in the epigastric region, may be relieved by the application of leeches to that part, which have been much recommended by Dr John Sims; and M. Lorentz. I have so often found advantage from this remedy, that I speak of it with confidence. If these means fail in procuring speedy relief, it is necessary to refrain for a time eating, and have recourse to nourishing clysters, or to give only a spoonful of milk, soup, &c. at a time. When the vomiting is bilious, and accompanied with pain in the right side and shoulder, cough, and other symptoms of hepatitis, a seton should be immediately introduced into the side, and a very gentle course of mercury given; for if the medicine be given freely, it produces much debility, or abortion, and sometimes accelerates the fate of the patient.

When vomiting is troublesome in the conclusion of pregnancy, it is proper to detract blood, and confine the person to bed. Cloths, dipped in laudanum, should be applied to the pit of the stomach, and a grain of solid opium may be given internally; but if this do not succeed, it is not proper to give larger and repeated doses. Gentle laxatives must be employed.

#### SECTION FOURTH.

Heartburn often takes place very early after conception, but sometimes not till after the fourth month. This is a complaint so very common, and so generally mitigated by absorbents, such as magnesia or chalk, that we are seldom consulted respecting it. But when it becomes very severe and intractable, it is requisite to try the most powerful of these means, such as calcined magnesia, combined with pure ammonia. When these fail, the aerated alkaline water, or the chalk mixture, with a large proportion of mucilage, may give relief. In obstinate cases, venesection and laxatives are

useful. Emetics have been proposed by Dr Denman, but they may sometimes cause abortion. They are only allowable where there is a constant screatus of disagreeable phlegm. In every severe case the diet must be carefully attended to. Pyrosis is to be relieved chiefly by laxatives, such as the aloetic pill or rhubarb and magnesia, and rubbing the epigastric region with anodyne balsam.

#### SECTION FIFTH.

Women, during gestation, are subject to many *bizzarries* in their appetite, and often have a desire to eat things they did not formerly like. This desire is common in cases of abdominal irritation, as we see in those who are afflicted with worms, or have indurated or morbid fæces in the intestines. These longings, it has been thought dangerous to deny; for as it was supposed, that they depended upon some peculiar state of the child affecting the mother, it was imagined, that if this was not removed, the infant would sustain an injury, or might even bear the mark of the thing longed for. Into this doctrine, it is now unnecessary to enter, and it will be sufficient to add, that when the desire is placed upon any article of diet, it may be safely gratified, and, indeed, generally the inclination leads to some light and cooling regimen.

#### SECTION SIXTH.

Spasm of the stomach, or duodenum, may often be attributed to some irregularity of diet, to the action of cold, or to the influence of the mind. It is necessary to interfere promptly, not only because the pain is severe, but also because it may excite abortion, though I must own I have never known it have that effect. A full dose of laudanum, with ether, followed immediately by a saline clyster, is almost always successful; but when the attacks are renewed, then we must endeavour to prevent them by tonics, such as colomba, oxyde of bismuth, or preparations of steel. It is at the same time, essential that the bowels be kept open. Blood-letting is of service.



When spasm of the stomach takes place in the end of pregnancy, or about the commencement of parturition, with a sense of fulness or uneasiness in the head, it is necessary to detract blood, lest the patient be seized with convulsions. This remedy is likewise proper, when the pain is accompanied with tenderness about the epigastric region, heat of the skin, full pulse, and ruddy face. When pain proceeds from the passage of a biliary calculus, it is to be treated more solito.

#### SECTION SEVENTH.

Costiveness is a general attendant on pregnancy, partly owing to the pressure of the uterus on the rectum, and partly owing to the increased activity of the womb producing a sluggish motion of the bowels. We must not, however, neglect this state, because it naturally attends gestation, for it may occasion many evils. It certainly increases the irritability of the system, as well as some of the stomachic ailments; and is apt to cause irritation of the bowels, or piles. It may also either excite premature labour, or give rise to much inconvenience after delivery.

Magnesia is a very common remedy, because it at the same time relieves heartburn; but, when it fails, or is not required for curing acidity in the stomach, the common aloetic pill, or a combination of aloes with extract of hyocyamus, should the former gripe, may be employed. Castor oil is also given, either alone, or made into an emulsion with mucilage. Roderic a Castro advises the woman to attempt to have a stool every day, in order to keep up the habit.

It sometimes happens, that indurated faeces are accumulated in the rectum or colon, producing considerable irritation. This causes not only pain, but also an increased secretion of the intestinal mucus, which is passed either alone, or with blood, together with pieces of hard faeces. This state, like dysentery, is often accompanied with great tenesmus; but it may be readily distinguished, by examining per vaginam, for the rectum is found to be filled with

fæces. Our first object ought to be to remove the irritating cause, which might ultimately produce abortion. Clysters are of great efficacy, because they soften the fæces, and assist in emptying that part of the intestine which is most distended. These are to be, at first, of a very mild nature, and must be frequently repeated. It may even be requisite to break down the feculent mass, with the shank of a spoon, or some such instrument. After the rectum is emptied, laxatives, such as castor oil, or small doses of sulphate of magnesia must be given to evacuate the colon; and when the fæces are brought into the rectum, clysters must be again employed. After the bowels are emptied, hyocyamus should be given, to allay the irritation; or if this be not sufficient, and the pain and secretion of mucus, with tenesmus, still continue, an anodyne must be administered, but next day it is to be followed by a mild laxative. And if there be fever or considerable pain in the abdomen blood-letting will be necessary. If this costive state be neglected near the time of delivery, the labour is often protracted; and after delivery masses of indurated fæces come down from the colon, producing considerable pain and frequency of pulse. When there is much irritation and sensibility, upon pressing on the abdomen, either before or after delivery, it will be proper to detract blood, at the same time that we use the remedies already pointed out.

#### SECTION EIGHTH.

The bowels, instead of being bound, may be very open; or costiveness and diarrhœa may alternate with each other. The diarrhœa is of two kinds; a simple increase of the peristaltic motion, and increased mucous secretion; or a more obstinate disease, depending on debilitated and deranged action of the bowels. In the first kind, the discharge is not altered from the natural state, except in being thinner; the appetite is pretty good, and the tongue clean, or only slightly white. This is not to be checked, unless it go to a considerable extent, or continue long, or the patient be weak.

ened by it, or be previously of a debilitated habit. Anodyne clysters, or the confectio catechu, will then be of service. Should the pulse be frequent, and any degree of heat or tension be felt in the abdomen, venesection will be useful. In the second kind, the appetite is lost or diminished, the tongue is foul, and the patient has a bitter or bad taste, and occasionally vomits ill tasted or bilious matter; the breath is offensive, and often the head aches. The stools are very offensive, and generally dark coloured. In this case, small doses of rhubarb give great relief, and some are in the habit of adding two grains of ipecacuanha to each dose of the rhubarb. A light bitter infusion is also a useful remedy. Attention must be paid to the diet, which is to be light, and the food taken in a small quantity at a time. Considerable benefit is derived from the soda water, which generally abates the sickness. When the tongue becomes cleaner, and the stools more natural, anodyne clysters may be administered. In all cases of continued diarrhœa, it is useful to have the surface kept warm with flannel; and sometimes a flannel roller, bound gently round the abdomen, gives great relief.

#### SECTION NINTH.

Pregnant women are very subject to piles. This may be partly owing to the pressure of the womb upon the vessels of the pelvis, but is chiefly to be attributed to a sluggish state of the intestinal canal, communicating a similar torpor to the hemorrhoidal veins. As this state is attended with costiveness, the disease has been considered as dependent on the mechanical action of the fæces; but whatever truth may be in this opinion in some cases, yet generally it is without foundation; and it is no unusual thing for those who are subject to piles, to be able to foretell an attack, by the appearance of peculiar symptoms, indicating diminished action of the alimentary canal. The treatment of this disease is twofold. We are to remove the cause by such means as give a brisker action to the bowels, such as bitters and laxatives; which last are also of great service, by removing the irrita-



tion of the fæces from the rectum, and rendering them softer, by which the expulsion gives less pain. For this purpose, cream of tartar alone, or combined with sulphur, has been generally employed ; but we may, with equal advantage, give small doses of castor oil, or of any of the mild neutral salts, dissolved in a large quantity of water. Besides removing the cause, we must likewise lessen the effect, by such local means as abate irritation and sensibility. When the pain, inflammation, and swelling, are great, it is of service to detract blood topically, by the application of leeches, or by making small punctures with a lancet. If there be considerable fever, bloodletting may be necessary, and the diet should be spare ; all stimulants and cordials must be avoided. Cooling and anodyne applications to the tumor are also very proper, such as an ointment containing a small quantity acetate of lead, or a weak solution of the acetate of lead in rose water, or a mixture of the acetum lithargyri and cream. Sometimes astringents are of service, such as the gall ointment ; or narcotics, such as opium\* or belladonna. If these means fail, it will be proper to give an anodyne clyster, and apply fomentations or emollient poultices to the tumor. In some cases, the tumor becomes slack, and subsides gradually ; in other instances it bursts, and more or less blood is discharged. If the hemorrhage be moderate, it gives relief ; but if profuse, it causes weakness, and must be restrained by pressure and astringents. Great pain, or much hemorrhage, are both apt to excite abortion.

#### SECTION TENTH.

The bladder is often affected by pregnancy. In some instances like the intestines, it becomes more torpid than formerly ; so that the woman retains her water long, and expels it with some difficulty, and in considerable quantity at a time. This state requires great attention, for retroversion of the uterus may, at a certain stage of gestation, be

\* Dr Johnston advises the following ointment to be applied, and then a poultice to be laid over the tumor. R. Ol. Amygd.  $\frac{3}{4}$  i. Ol. Succini  $\frac{3}{4}$  ss. Tk. Opii.  $\frac{z}{ii}$ . M. *System* p. 125.

readily occasioned. There is not much to be done with medicines in this case ; for, although soda, and similar remedies, sometimes give relief, yet more reliance must be placed on the regular efforts of the patient. Should these be delayed too long, then the catheter must be employed.

More frequently the bladder is rendered unusually irritable, especially about its neck, and the urethra participates in this state. There is also, in many instances, an uneasiness felt in the region of the bladder itself. This state requires a very different treatment from the former, for here it is our object to avoid every saline medicine which might render the urine more stimulating. Relief is to be expected by taking away blood, giving small doses of castor oil, and, occasionally, the extract or tincture of hyocyamus, and encouraging the patient to drink mucilaginous fluids, which, if they do not reach the bladder as mucilage, at least afford a bland addition to the blood, from which the urine is secreted. This state of the bladder is sometimes productive of a slight irritation about the symphysis of the pubis, rendering the articulation less firm and more easily separated. In such circumstances, when the pubis is tender, blood-letting and rest are the two principal remedies.

A very distressing affection, which is often conjoined with this state of the bladder and urethra, but which may also take place without it, is a tender and irritable state of the vulva, producing great itching about the pudendum, especially during the night, and generally the urine is felt very hot. This distressing condition is often alleviated by blood-letting and laxatives ; and when the itching is great, a sponge, dipped in cold water, or in cold solution of cerussa acetata, should be applied. If much fever exist, the saline julap, combined with a little tincture of opium, is useful.

Incontinence of urine is not uncommon, in the end of gestation, and is produced by the pressure of the uterus on the bladder, by which the urine is forced off involuntarily, whenever the woman coughs or moves quickly ; or at least she cannot retain much of it, being obliged to void it frequently, but without strangury. For this complaint there is no

cure; and many consider it as a favourable omen, that the child's head is resting on the os uteri. When the uterus is very pendulous, some advantage may be obtained, by supporting the belly with a proper bandage attached to the shoulders.

#### SECTION ELEVENTH.

Connected with the state of the alimentary canal, is the jaundice of pregnant women. This disease appears at an early period, and is preceded by dyspeptic symptoms, which generally increase after the yellowness comes on. In some instances, the tinge is very slight, and soon disappears. In other cases, the yellow colour is deep and long continued, and the derangement of the stomach and bowels considerable. Emetics, and other violent remedies, which are sometimes used in the cure of the jaundice, are not allowable in this case; and in every instance, when young married women are seized with jaundice, we should be very cautious in our prescriptions. Gentle doses of calomel, or of other laxatives, with some light bitter infusion, are the most proper remedies; and generally the complaint soon goes off. Jaundice may also take place in the end of gestation; and in this case, it proceeds most frequently from pressure on the gall duct. Sometimes, however, it is dependent on a disease of the liver itself, which may occur at any period of gestation, and is marked by the usual symptoms. In this case, the danger is very great, and can only be averted by taking cautious measures for removing the hepatic disease.

#### SECTION TWELFTH.

In some cases, the skin is partially coloured; the mouth, for instance, being surrounded with a yellow or brown circle, or irregular patches of these colours appearing on different parts of the body. This is an affection quite independent of the state of the bile, and seems rather to be connected with certain conditions of the alimentary canal. It goes off after delivery, and does not require any peculiar treatment.



## SECTION THIRTEENTH.

The thoracic viscera not unfrequently suffer during pregnancy. Palpitation of the heart is a very common affection, and extremely distressing. It is a disease so well known, that it is needless here to describe it; but it may not be improper to observe, that women themselves sometimes mistake for it a strong pulsation of the arteries, at the upper part of the abdomen. It may make its attack repeatedly in the course of the day; or only at night, before falling asleep; or at the interval of two or three days; and is very readily excited by the slightest agitation of the mind. It is generally void of danger; but in delicate women, and in those who are disposed to abortion, it sometimes occasions that event; and if long continued, it may excite pulmonary disease in those who are predisposed to it. Absolute rest, with antispasmodics, are requisite during the paroxysm. Hartshorn, ether, and tincture of opium, may be given, separately or combined. Roderic a Castro prescribes a draught of hot water. The attacks are to be prevented by the administration of tonics, such as tincture of muriated iron; and of fœtids, such as valerian and asafoetida. Fatigue and exertion must be avoided, and the mind kept tranquil. If the person be plethoric, it is sometimes useful to take away a little blood. The bowels are to be carefully kept open. The diet must be attended to; for it is often produced by a disordered stomach.

A tendency to nervous or hysterical diseases is to be prevented, in those who are liable to them, by occasional blood-letting, the use of laxatives, and camphor, or fœtids. Opiates are only to be given for the immediate relief of urgent symptoms.

## SECTION FOURTEENTH.

Another distressing affection of the heart, attendant on pregnancy, is syncope. This may take place at any period of gestation, but is most frequent in the three first months, or about the time of quickening. It may succeed some little

exertion, or speedy motion, or exposure to heat; but it may also come on when the person is at perfect rest. The paroxysm is sometimes complete, and of long duration; at other times, the person does not lose her knowledge of what is going on, and soon recovers. A recumbent posture, the admission of cold air, or application of cold water to the face, the use of volatile salt, and the cautious administration of cordials, constitute the practice during the attack. Should the fit remain long, we must preserve the heat of the body, otherwise a protracted syncope may end in death. Those who are subject to fainting fits, must avoid fatigue, crowded or warm rooms, fasting, quick motion, and agitation of the mind. Tonics are sometimes useful.

There is a species of syncope, that I have oftener than once found to prove fatal in the early stage of pregnancy, which is dependent, I apprehend, on organic affections of the heart, that viscus being enlarged, or otherwise diseased, though perhaps so slightly as not previously to give rise to any troublesome, far less any pathognomonic symptoms. Although I have met with this fatal termination most frequently in the early stage, I have also seen it take place so late as the sixth month of pregnancy.

#### SECTION FIFTEENTH.

Sudden attacks of dyspnœa in those who were previously healthy, are generally to be considered as hysterical, and are readily removed by antispasmodics. There is, however, a more obstinate and protracted symptom, not unfrequently connected with pregnancy, namely cough. This may come in paroxysms, which are generally severe, or it may be almost constant, in which case it is short and teasing. Sometimes a viscid fluid is expectorated, but more frequently the cough is dry. During the attack, the head is generally painful, and the woman complains much of the shaking of her body, especially of the belly. All practical writers are agreed with respect to the danger of this disease, for it is extremely apt to induce abortion; and it is worthy of remark, that after the child is expelled, the cough

often suddenly ceases. But exposure to cold frequently brings it back; and should there be a predisposition to phthisis, that disease may be thus excited. Blood-letting must be early, and sometimes repeatedly employed; the bowels kept open; and lozenges, containing opium or hyocyamus, must be occasionally used, to allay the cough. A large burgundy pitch plaster, applied betwixt the shoulders, is of service. Should abortion take place, and the cough continue, tonics, such as myrrh and oxyde of zinc, ought to be administered.

#### SECTION SIXTEENTH.

In some instances, hæmoptysis or hæmatemesis take place in pregnancy, especially in the last months, and these are very dangerous affections. Blood-letting is the remedy chiefly to be depended on; and afterwards laxatives should be given, acids and hyocyamus may be employed to allay irritation. If these means do not succeed, the patient dies. Should the hemorrhage take place during labour, or should pains come on prematurely, and the os uteri dilate, as sometimes happens, it will be prudent to accelerate the delivery.

#### SECTION SEVENTEENTH.

Headach is a very alarming symptom, when it is severe, constant, and accompanied with symptoms of plethora. If the eye be dull or suffused, and the head giddy, especially when the person stoops or lies down, with a sense of heaviness over the eyes, or within the skull, great danger is to be apprehended, particularly if the woman be far advanced in her pregnancy. This is still more the case, if she complain of ringing in the ears, and flashing of fire in the eyes, or indistinct vision. In such circumstances, she is seized either with apoplexy or epilepsy. These diseases are to be prevented by having immediate recourse to blood-letting and laxatives; and the same remedies are useful, if either one or other of these diseases have already taken place. The quantity of blood which is to be detracted, must be determined



by the severity of the symptoms, the habit of the patient, and the effect of the evacuation; but, generally, moderate evacuation will prevent, whilst very copious depletion is requisite to cure these diseases. If the headach be accompanied with œdema, the digitalis is a useful addition to the practice. I shall not at present enter farther into the history or treatment of epilepsy, as the subject will be hereafter resumed.

It is farther proper to remark, that, if the patient is seized with apoplexy, there is seldom any attempt made to expel the child\*, and, in my own practice, I have never known that event take place. In epilepsy, on the contrary, if the paroxysm be protracted, there is generally an effect produced on the uterus; its mouth opens, and the child may be expelled, if the patient be not early cut off by a fatal coma. Whenever expulsive effects come on, we must conduct the labour according to rules hereafter to be noticed. In some instances, palsy either succeeds an apoplectic attack, or follows headach and vertigo. This disease does not commonly go off until delivery have taken place; but it may be prevented from becoming severe, by mild laxatives and light diet; and, after the woman recovers from her labour, the disease gradually abates, or yields to appropriate remedies.

All headaches, however, do not forbode these dismal events, for often they proceed from the stomach, and evidently depend on dyspepsia, or nervous irritation. These are generally periodical, accompanied with a pale visage, they feel more external than the former, and are often confined to one side of the head. They are attended with acidity in the stomach, eructations, and sometimes considerable giddiness or slight sickness, with bitter taste in the mouth. They are relieved by the regular exhibition of laxatives, by sleep, the moderate use of volatiles, and the application of ether externally.

#### SECTION EIGHTEENTH.

Toothach not unfrequently attends pregnancy, and, some-

\* Mr Wilson's case is an exception to this. Vide Med. Facts, vol. v. p. 96.

times, is a very early symptom of that state. The tooth may be sound or diseased, but, in neither case, ought we to extract it, if it be possible to avoid the operation. I have known the extraction followed in a few minutes by abortion. Blood-letting frequently gives relief, and, sometimes, a little cold water taken into the mouth abates the pain. In other cases, warm water gives more relief.

#### SECTION NINETEENTH.

Salivation is, with some women, a mark of pregnancy. It has been supposed that there is a sympathy existing between the pancreas and salivary glands, and that the phlegm rejected by vomiting proceeded from the former, whilst, in many instances, the latter yielded an increased quantity of viscid saliva. This is a symptom which scarcely demands any medicine, but, when it does, mild laxatives are the most efficacious.

#### SECTION TWENTIETH.

Pain and tension of the mammæ frequently attend gestation, and these symptoms are often very distressing. If the woman have formerly had a suppuration of one mamma, that breast is generally most painful, and she is afraid of abscess again forming. In other instances, the pain, being accompanied with increased hardness of the breast, produces apprehension of cancer. These fears are generally groundless; but if suppuration do take place, it is to be treated on general principles. Blood-letting often relieves the uneasy feeling in the breast, which is also mitigated by gentle friction with warm oil. Nature often gives relief, by the secretion of a serous fluid which runs out from the nipple; but if this be much encouraged by suetion, Chambon remarks, that the foetus may be injured. The discharge is in some instances so great about the 7th month, or later, as to keep the woman very uncomfortable. The diet in this case should be dry.

The sudden abatement of the tension, and fulness of the breasts, with a diminution of size, are unfavourable circumstances, indicating either the death of the child, or a feeble action of the womb.

## SECTION TWENTY-FIRST.

In the course of gestation, the feet and legs very generally become œdematous ; and sometimes the thighs, and labia pudendi participate in the swelling. The swelling is by no means proportioned always to the size of the womb, for, as has been remarked by Puzos, those who have the womb unusually distended with water, and those who have twins, have frequently very little œdema of the feet. This disease is partly owing to the pressure of the uterus, but it also seems to be somewhat connected with the pregnant state, independent of pressure ; for in some instances, the œdema is not confined to the inferior extremities, but affects the whole body. A moderate degree of œdema going off in a recumbent posture is so far from being injurious, that it is occasionally remarked, that many uneasy feelings are removed by its accession ; but a greater and more universal effusion indicates a dangerous degree of irritation, and may be followed by epilepsy. In ordinary cases, no medicine is necessary except aperients ; but, when the œdema is extensive or permanent, remaining even after the patient has been for several hours in bed, it may be attended with unpleasant or dangerous effects, such as convulsions ; or, it may predispose to puerperal diseases ; we must therefore lessen it by means of those agents which alleviate the other diseases of pregnancy ; namely, blood-letting and purgatives. These means are always proper, unless the strength be much reduced ; in which case, we only employ the purgatives and cordials prudently, with acetate of pot-ash, or sweet spirit of nitre. Diuretics, generally, are not successful, and many of them, if given liberally, tend to excite abortion. Friction relieves the feeling of tension.

## SECTION TWENTY-SECOND.

Ascites may, like œdema, be excited, in consequence of some condition connected with gestation, or may be independent of it, arising from some of the ordinary causes of dropsy, especially from a disease of the liver. In the last



case, medicine has seldom much effect in palliating or removing the disease; and the woman usually dies, within a week or two after her delivery, whether that have been premature, or delayed till the full time. When ascites is not occasioned by hepatic disease, it is generally connected with the œdematous state above mentioned, and seldom appears until the woman has been at least three months pregnant. If it be not attended with other bad symptoms, such as head-ach, feverishness, drowsiness, &c. it abates and goes off, a little before, or soon after delivery, which is often premature. I have seen diuretics given very freely in these cases, but most frequently without any benefit. On this account, and also from the danger of these exciting abortion, or premature labour, I am inclined to dissuade from their use, except in urgent cases. Then the mildest ought to be employed, such as cream of tartar, juniper tea, acetate of pot-ash, &c. If any of these produce much irritation of the urinary organs, they must be exchanged for others. Purgatives and blood-letting are more useful. If this, or any other dropsical affection, appear as a symptom rather of a broken constitution than as connected with pregnancy, mild diuretics and calomel are chiefly to be employed.

If the water is not absorbed soon after delivery, immediate recourse must be had to tapping, and afterwards to diuretics.

#### SECTION TWENTY-THIRD.

When the liquor amnii is in too great quantity, much inconvenience is produced, and not unfrequently the child perishes. This disease is known, by the woman being unusually large at an early period of gestation, for generally by the seventh month, she is as big as she ought to be in the ninth. It is distinguished from ascites, by the motion of the child being felt, though obscurely by the mother, and the breasts enlarging. Per vaginam we can ascertain, that the uterus contains a substance, which alternately recedes and descends as the finger strikes on the lower part of the womb. This is to be considered as a dropsical affection of the ovum, but the health of the woman seldom suffers so much as in

dropsy; the tongue, however, is white, and the urine is diminished in quantity. The legs are less apt to swell than in a common pregnancy. The distension may, in the advanced stage, prove troublesome. When the quantity of water is greatly increased, the child is seldom kept till the full time, but is generally expelled in the eighth month, or sooner, and the labour is apt to be accompanied or succeeded by uterine hemorrhage. In some instances, the child occupies the upper part of the uterus, and the water the under, at least during labour. Twice in the same woman, in succeeding pregnancies, I found the child contained in the upper part of the uterus, and embraced by it as if it were in a cyst, whilst several pints of water lay between it and the os uteri. When the water came away, filling some basons, then the child descended to the os uteri, but was born dead, with the thighs turned firmly up over the abdomen, and other marks of deformity.

This is a disease of the ovum and not of the mother, for even the foetus itself is often malformed, or at least blighted. The affection in toto, may be considered as a species of monstrous conception. Some particular condition of the parent may, however, in certain cases, occasion it. For instance, it may be connected with a syphilitic taint in either the father or mother; or with some less obvious cause impairing the action of the womb, but not directly producing a miscarriage; with lunacy or idiotism; or with a state of general or uterine debility; or with an original imperfection of the ova in the ovarium: for a woman may, without any apparent cause, have repeatedly this kind of pregnancy. All of these causes do not operate uniformly to the same extent, but the foetus suffers in proportion to their operation. It is either born very feeble and anguid, and is reared with difficulty, or it dies almost immediately, or it perishes before labour commences; and this is generally the case when the diseased state exists to any great degree. The period of the child's death is usually marked by a shivering fit, and cessation of motion in utero, at the same time that the breasts become flaccid. Afterwards irregular pains come on, with or

without a watery discharge. Sometimes the woman is sick or feverish for a few days before labour begins.

If the liquor amnii be not increased greatly beyond the usual quantity, the woman may go the full time, but, from the distension of the uterus, is apt to have a lingering labour.

Tonics, the cold bath, dry diet, with occasional venesection, and the use of laxatives, during pregnancy, may be of service, but frequently fail. Diuretics do no good. A course of mercury conducted prudently, previous to conception, is the only remedy, when we suspect a syphilitic taint. It may be necessary to prescribe it to both parents. When it proceeds from some more latent cause, I think it is useful, for preventing a repetition of the disease, to make the mother nurse, even although her child be dead. Mercury ought also to be tried.

When the distension produces much distress, it has been proposed to draw off the water by the os uteri; or this has been done in one case by the common operation of paracentesis, the woman surviving, and labour taking place on the twenty-first day \*. This practice is, however, generally improper, and is seldom requisite, pains usually coming on whenever the symptoms become severe. When the os uteri is considerably dilated by the pains, it may be proper to rupture the membranes, as has been advised by Puzos.

#### SECTION TWENTY-FOURTH.

Discharges of watery fluid from the vagina are not unfrequent during pregnancy, and generally depend upon secretion from the glands about the cervix uteri. It has been supposed, that in every case they proceeded from this cause, or from the rupture of a lymphatic, or the evacuation of a fluid collected between the chorion and amnion, or the water of a blighted ovum, in a case of twins; for in every instance where the liquor amnii has been artificially evacuated, labour has taken place. But we can suppose, that the action of gestation may, in some women, be so strong, as not

\* Vide case by Noel Desmarais, in *Recueil Period.* Tom. VI. p. 349. M. Baudelocque gives a memoir on this subject in the same volume.



to be interrupted by a partial evacuation of the liquor amnii. Even granting the water to be collected exterior to the chorion, there must be a strong tendency to excite labour, if the quantity discharged be great\*; and if the uterus can resist this, it may also be unaffected by the evacuation of liquor amnii. I have known instances, where after a fright or exertion, a considerable quantity of water has been suddenly discharged, with subsidence of the abdominal tumor, or feeling of slackness; and even irregular pains have taken place, and yet the woman has gone to the full time†. These prove, as far as the nature of the case will admit of proof, that the water has been evacuated. Sometimes, only one discharge has taken place, but oftener the first has been followed by others; and these are often tinged with blood. The aperture seems to heal, if gestation go on; for during labour, a discharge of water takes place. Much more frequently labour does take place. Even when the discharge proceeds only from the vessels or glands about the os uteri, if the woman be not careful, a hemorrhage may take place, followed by labour. This is most likely to happen if there have been a copious discharge.

The practice, in these cases, is to confine the patient for some time to bed. An anodyne ought also to be given, and may be repeated occasionally, if she be effected either with irregular pain, or nervous irritation; previous venesection often renders this more useful. The bowels are to be kept open. If we suppose the discharge to be from the glands or vessels about the os uteri, we may, with advantage, inject some astringent fluid, such as a solution of sulphate of alumine.

It sometimes happens, that a large hydatid is lodged between the orum and the os uteri, and it may be expelled se-

\* Vide Dr Alexander's case, in *Med. Comment.* Vol. III. p. 187.

† Dr Pentland relates a very distinct case, where the liquor was, in the third or fourth month, discharged in a fit of coughing. The belly fell, but she still went on to the full time, and had a good labour. *Dublin Med. and Phys. Essays*, No. I. art. 3.—I have known a discharge of water take place, at short intervals, for some weeks; and then the funis umbilicalis protruded, without any exertion or any pains to rupture the membranes, which is a demonstration that the membranes had been previously open, and that the discharge of liquor did not speedily excite labour.

veral weeks before parturition. If care be not taken, this may be followed by hemorrhage.

#### SECTION TWENTY-FIFTH.

Varicose tumors sometimes appear on the legs. They are not dangerous, but are often painful. By pressure, they can be removed; but I am not sure that it is altogether safe to apply a bandage round the legs, so tight as to prevent their return. It is better, in ordinary cases, to do nothing at all; but where there is much pain, a recumbent posture, and moderate pressure give relief.

#### SECTION TWENTY-SIXTH.

From the distension of the abdominal muscles, pain may be produced; either about the extremities of the recti muscles, or the origins of the oblique or transverse muscles. These pains are not dangerous, but give unnecessary alarm if the cause be not known. It is impossible to remove them, but they may be mitigated by anodyne embrocations. If the pain be severe along the edge of the ribs, relief may be obtained by applying round the upper part of the abdomen a narrow band of leather, spread with adhesive plaster.

There is another cause of pain, which sometimes affects these muscles, but oftener those about the pelvis and hips. This seems to consist in a diminished power of the muscles, in consequence of the uterine action, and thus the fibres are not capable of the same exertion as formerly. A long walk, or some little fatigue, may produce such an effect, as to render them painful for a long time; or even without any unusual degree of motion, they may ache, and produce the sensation of weariness. These pains have been supposed to be most frequent when the woman has twins, but this is far from being a general rule. They may occasion an apprehension that she is going to miscarry. Rest is the principal remedy, but if they be severe, relief may often be obtained by venesection.

Pain in the side, particularly the right side, is sometimes at an advanced period of gestation, both muscular, and also

connected with the state of the bowels, especially of the colon. It is frequently most severe, and may be rendered still more distressing by being combined with violent heartburn, or water-brash. It comes on chiefly at night, and instead of being relieved by lying down, is often increased on going to bed. It is usually accompanied with much motion of the child. Venesection sometimes gives relief, but generally more advantage is derived from rubbing with anodyne balsam, attending to the state of the bowels, and regulating the diet. Although the pain be very severe, it seldom brings on labour.

#### SECTION TWENTY-SEVENTH.

Spasm of the ureter, or some violent nephritic affection, may occur during gestation. The pain is severe, the pulse slow and soft, and the stomach often filled with wind. The symptoms are attended with distressing strangury, and, if not soon removed, may cause premature labour. Decided relief is obtained by giving a saline clyster, and, after its operation, injecting eighty drops of laudanum, mixed with a little starch. A sinapism is to be applied to the loin, and if these means fail, blood must be taken away.

#### SECTION TWENTY-EIGHTH.

Spasms in the inferior extremities are often very distressing. These may come on suddenly, but occasionally they are preceded by a sense of coldness, and accompanied with a feeling of heat. They are removed by change of posture, and gentle friction. They have, by some, been thought to indicate a wrong presentation of the child, but this opinion is not supported by experience. They proceed from the pressure of the uterus on the nerves in the pelvis.

#### SECTION TWENTY-NINTH.

In a first pregnancy, the abdominal muscles generally preserve a greater degree of tension than they do afterwards; and therefore the belly is not so prominent as in succeeding pregnancies. Sometimes the muscles and integuments yield so readily to the uterus, that it falls very much forward,



producing a great prominence in the shape, inconvenience from the pressure on the bladder; and pain in the sides, from the increasing weight of the projecting uterus. In such cases, benefit may be derived from supporting the abdomen with a bandage connected with the shoulders. In other instances, the muscles and integuments do not yield freely, but the belly is hard and tense; the woman feels shooting pains about the abdomen, and sometimes miscarries. This state is relieved by blood-letting and tepid fomentations. When the skin does not distend freely, and becomes tender and fretted, or when these effects are produced by very great distension, benefit is derived from fomenting with decoction of poppies, and afterwards applying a piece of soft linen, spread very thinly with some emollient ointment.

There is sometimes a disposition to distend unequally, so that one side yields more than the other, or even part of one side, or one muscle more than the rest, producing a peculiar shape. This is attended with no inconvenience.

#### SECTION THIRTIETH.

It is very usual for the navel of pregnant women to become prominent, even at an early stage. In some instances, such a change is produced, as to allow the intestine or omentum to protrude, forming an umbilical hernia; or if the woman have been formerly subject to that disease, pregnancy tends to increase it, whilst, on the other hand, the intestines being soon raised up by the ascending uterus, inguinal and femoral herniæ are not apt to occur, or are even removed if they formerly existed. Umbilical hernia ought to be either kept reduced by a proper bandage, or at least prevented, by due support, from increasing; and during delivery, we must be careful that the intestine be not forcibly protruded, as it might be difficult to replace it. After delivery, a bandage must be applied.

In some cases, during gestation, the fibres of the abdominal muscles separate, so that a ventral hernia is formed. The same circumstance may take place during parturition;

and the laceration is sometimes so large, that afterwards, whenever the muscles contract, as, for instance, in the act of rising, a quantity of intestine is forced out, forming a hard tumor like a child's head. It is necessary in this, and in all other cases of large hernia, to be careful that compression be applied immediately after delivery, and also during the expulsion of the child. By neglecting this, syncope and uterine hemorrhage have been occasioned.

Herniæ of the bladder should always be reduced in the commencement of labour, for it may interfere with the process of parturition, or the bladder may be exposed to injury.

#### SECTION THIRTY-FIRST.

It is not uncommon to find women very desponding during pregnancy, and much alarmed respecting the issue of their confinement. This apprehensive state may be the consequence of accidents befalling others in parturition; but not unfrequently it proceeds from a peculiar state of mind, dependent on gestation. Some, who at other times enjoy good spirits, become always melancholy during pregnancy, whilst others suffer chiefly during lactation. Little can be done by medicine, except to obviate all cause of disease or uneasiness of the body; the mind is to be cheered and supported by those who have most influence with the patient.

#### SECTION THIRTY-SECOND.

Retroversion of the uterus was described by Levret and Gregoire, but was in this country first accurately explained by Dr Hunter in 1754. It is an accident, which is always attended with very serious, and sometimes fatal consequences, chiefly owing to the effect produced on the bladder. If the pelvis be of the usual size, it may take place at any time between the third and fourth month of pregnancy, or whenever the womb is enlarged to a certain degree by disease<sup>1</sup>. We recognise retroversion of the uterus chiefly by its effects on the bladder, and also by difficulty in voiding the fæces;

for although the patient may be distressed sometimes with tenesmus, she usually passes little at a time. When the retroversion is completed, bearing-down pains may be excited, as if an attempt were made to expel or force down the uterus itself. These are much connected also with the state of the bladder, being most severe when it is distended, and abating when the urine is evacuated. The acute symptoms produced by the distension of the bladder, or the inability to pass the urine freely, first of all call the attention of the woman to the disease; and when we come to examine her, we find a tumor betwixt the rectum and vagina<sup>2</sup>. This is formed by the fundus uteri, which is thrown backwards and downwards, whilst the os uteri is directed forward, and sometimes so much upwards, as not to be felt by the finger. This is a disease which we would think cannot be mistaken; and yet it is sometimes difficult to distinguish it; for in extra-uterine pregnancy, it has happened, that the symptoms have been nearly the same with those of retroversion\*; and tumor of the ovarium has sometimes produced similar effects. Perhaps the diagnosis cannot, in every case, be accurately made, but this is of less immediate importance, as the indications in such instances must be the same, namely, to evacuate the bladder, and procure stools.

Retroversion may take place slowly, and it has been said that its progress could be ascertained from-day to day<sup>3</sup>; but in most instances, and in every case that I have seen, it has taken place pretty quickly; and occasionally the woman has been sensible at the time, of a tumbling or motion within the pubis. Sometimes the urine dribbles away involuntarily, or can be passed in small quantity, especially during the commencement of the disease; but often, within a few hours, it becomes almost completely obstructed, with pains about the loins, tenderness in the lower belly when it is touched, and a severe bearing down sensation. The great danger proceeds from the distension<sup>4</sup> of the bladder, which

\* Vide Mr Giffard's case, in *Phil. Trans.* Vol. XXXVI. p. 435; and Mr White's very instructive case, in *Med. Comment.* Vol. XX. p. 254.



either bursts<sup>5</sup> or inflames<sup>6</sup>, and an opening takes place, in consequence of gangrene; or the bladder adheres to the abdominal parietes, its coats becoming thickened and diseased<sup>7</sup>. If the urine cannot be drawn off, of which I have never yet met with an instance, death is preceded by abdominal pain, vomiting, hiccup, and sometimes convulsions. The duration of these symptoms is variable †. Inflammation and gangrene of the vagina and external parts have also been produced. If the disease do not prove rapidly fatal, so much urine escaping as to prevent a speedy termination, it occasionally happens, that hectic fever is produced. The pulse becomes frequent, the body wastes, and purulent urine is voided<sup>8</sup>; or the person may become œdematous, and the disease pass for dropsy<sup>9</sup>; occasionally the water is not quite obstructed, but it is voided with difficulty for a week or two, and then the symptoms become more acute, and forcing pains are excited.

Our first object is to relieve the bladder, by introducing a catheter<sup>10</sup>, which may be slightly curved, the concavity being directed to the sacrum; or we may employ an elastic catheter; but in general, the common instrument succeeds. If it do not pass easily, we may derive advantage from introducing the finger into the vagina, and endeavouring to depress the os uteri, or press back the vaginal tumor<sup>11</sup>. If the catheter cannot be introduced, we have been advised to tap the bladder<sup>12</sup>; but this, fortunately, is seldom requisite.

We must not be deceived with regard to the state of the bladder, by observing that the woman is able to pass a small quantity of water, for it may, nevertheless, be much distended. We must examine the belly, and attend to the sensation produced by pressure on the hypogastric region. Even although the catheter have been employed, only part of the urine may have been drawn off, particularly if the complete evacuation has not been assisted by moderate pressure over the bladder. It has happened, that only so much has been taken away as to give a little relief, and alter the position of the uterus so much as to lessen the pressure on the orifice of the bladder. In this case, on getting up, a great quantity

† Dr. Ferri's patient died thus on the sixth day. *Cases in Midwifery*, Vol. I. p. 394

of urine has flowed spontaneously, and the womb immediately returned to its proper state.

The urine being evacuated, and the most immediate source of alarm being thus removed, we must, in the next place, procure a stool, by means of a clyster; detract blood, if there be fever or restlessness; and give an anodyne injection, if there be strong bearing down efforts. This is, in general, all that is requisite; and I wish particularly to inculcate the necessity of directing the chief attention to the bladder, which ought to be emptied at least morning and evening. By this plan, we generally find, that the uterus resumes its proper situation in the course of a short time, perhaps in forty-eight hours;<sup>15</sup> and seldom is the retroversion continued for more than a week, unless the displacement has been very complete. The precise time, however, required for the ascent of the womb will be determined *ceteris paribus*, by the degree to which it has been retroverted, and the attention which is paid to the bladder. If the fundus be very low, the ascent may be tedious, or it may even be requisite to use means to raise it; but I consider myself as warranted from experience to say, that in every moderate degree of retroversion, in every recent case, it is sufficient to empty the bladder regularly, without making any attempt to push up the womb. But if the uterine tumour be very low, and near the perineum, it may be necessary, and certainly it is allowable, to endeavour to replace the womb. This is also proper, if there be much irritation excited by the state of the womb, and which does not give way to the use of the catheter, and of anodyne clysters.

The attempt to replace the uterus is to be made by introducing two fingers of one hand into the rectum, and a sufficient number of those of the other hand, or the whole hand itself, into the vagina. The uterine tumor is then to be pressed up slowly, firmly, and steadily; and this may sometimes be assisted by elevating the breech of the woman. Forcible and violent attempts are, however, to be strongly reprobated: they give great pain, and may even excite abortion, inflammation, or convulsions. They can only be justified

on the principle of preventing a great danger. Now we know that the chief risk proceeds from the distension of the bladder; if, therefore, it can be emptied, the danger is usually at an end. When the retroversion ceases, the uterus usually resumes completely its proper situation; but it sometimes happens, especially if the vagina have been much relaxed, that when the retroversion is removed, the uterus is found very low, forming a prolapsus, which continues for some time. It requires, chiefly, attention to the urine and stools; for it may occupy the pelvis fully, and pretty firmly; and almost the whole fœtus can be felt by the finger through the uterus.

When the uterus ascends, occasionally a little blood is discharged\*; but abortion does not take place unless much injury has been sustained. Thus the woman has miscarried quickly after the bladder had burst, as in Mr Lynn's patient; or when inflammation had taken place, as in the cases related by Drs Bell and Ross. When this happens, the uterus rises indeed, but the patient is cut off by peritoneal inflammation<sup>14</sup>, followed by vomiting of dark coloured stuff. Abortion will also take place, if the liquor amnii have been discharged.

That the uterus does generally rise spontaneously, if the urine be regularly evacuated, is a fact of which I am fully convinced from my own experience, as well as from the observations of others. But it is nevertheless possible for it to continue in a certain degree of malposition even to the end of gestation<sup>15</sup>. In this case, the uterus cannot, indeed, at last be said exactly to be retroverted; for it has enlarged so much, that it occupies nearly as much of the abdomen as usual; but it has enlarged in a peculiar way, the os uteri being still directed to the symphysis pubis, or ~~even~~ perhaps raised above it. In such a case, which is exceedingly rare, the labour will be very tedious and severe. The os uteri will be very long of being felt, and will be first perceived at the pubis.

\* M. Roger's case, in Act. Havre Toim. II. art. 17.



In order to prevent retroversion, we must understand its cause, which most frequently, if not always, consists in distension of the bladder. The os uteri is thus elevated, and the fundus falls in the same proportion backward. Now in the unimpregnated state, the fundus is not sufficiently heavy or large to fall down; and after the fourth month of pregnancy, the uterus is too heavy to be much raised by the bladder, and too large to fall into the pelvis. If, however, the pelvis be very wide, and the uterus have consequently been longer than usual of rising, it may be retroverted at a later period. It would appear, that agitation, or violent exertion<sup>16</sup>, may cause this state to take place more readily than would otherwise happen; but whether concussion, or other circumstances, can produce retroversion, without some previous distension of the bladder, is not positively proved, though some facts favour the supposition.

The same woman has been known to have the uterus retroverted in two successive pregnancies\*.

#### SECTION THIRTY-THIRD.

The uterus is also said to be sometimes antiverted, that is, the fundus is thrown forward, so as to compress the neck of the bladder, and its mouth is turned to the sacrum<sup>17</sup>. Of this accident I have never seen an instance, and, from the nature of the case, it must be very rare. The urine should be evacuated, and the fundus raised up.

#### SECTION THIRTY-FOURTH.

Rupture of the gravid uterus may take place at any period of gestation. The moment of the accident is generally marked by severe pain, occasionally by vomiting, and frequently by a tendency to syncope, which, in some instances, continues for a length of time to be the most prominent symptom†. The pain sometimes resembles labour, but more fre-

\* Vide case by Dr Senter, in Trans. of Phys. at Philadelphia, p. 130. Both times it was reduced by the hand.

† Vide Dr Underwood's case, in Lond. Med. Journ. Vol. VII. p. 321.

quently colic, and its duration is variable. In some cases, hemorrhage takes place from the vagina, but the greatest quantity of the blood<sup>18</sup> flows into the abdomen. At the time of the accident, and for a little thereafter, the child is felt to struggle violently. Then the motion ceases, the woman feels a weight in the belly, and, if the pregnancy be far advanced, the members of the child can be traced through the abdominal parietes<sup>19</sup>. The tumor of the belly generally<sup>20</sup> lessens, and milk is secreted, indicating the death of the child.

If hemorrhage, or peritoneal inflammation, do not quickly carry off the patient, we find, that at the end of some time, occasionally of the ninth month of gestation, pains like those of labour come on, which either gradually go off, and the child is retained for many years\*, being inclosed in a kind of cyst; or inflammation and abscess take place, and the child is discharged piece-meal<sup>21</sup>.

In some instances, it would appear, that the ovum may be expelled entire into the abdomen; and in that case, it is possible for the child to live for some time, and even to grow, although out of the uterus. When this happens, its motions are felt more freely and acutely than formerly. As the os uteri opens a little after the expulsion, and a sanguineous discharge takes place, the woman has sometimes been supposed to miscarry. If she survives, the womb slowly decreases in size, and returns to the unimpregnated state<sup>22</sup>, which will assist materially in the diagnosis, between this and extra-uterine pregnancy existing from the first. The menses return, and though the belly does not subside completely, yet the person continues tolerably well, unless inflammation come on. She may even bear children before the extra-uterine fœtus be got rid of†. If the case is to prove fatal, the pulse becomes quick and small, the belly painful, the strength sinks, and sometimes continued vomiting ushers in dissolution<sup>23</sup>.

\* In Dr Percival's case, the fœtus was retained for 22 years, and then discharged by the rectum.

† Vide Journ. de Med. Tom. V. p. 422.

Rupture of the uterus may be the consequence of mental agitation \*, but in most cases it is owing to external violence<sup>21</sup>.

Three modes of treatment present themselves. To leave the case to nature ; to deliver *per vias naturales* ; and to perform the cæsarean operation. To dilate the os uteri forcibly, and thus extract the child, is a proposal so rash and hazardous, that I know none in the present day who would adopt it. I question if the woman would live till the delivery were accomplished. The cæsarean operation is safer, and in every respect preferable ; but we cannot yet, from experience, determine its advantages, and certainly it ought not to be performed unless we can thereby save the child. The third proposal, therefore, to leave the case to nature, like an extra-uterine pregnancy, is most likely to be successful, more especially when the rupture happens in the early months of gestation. We find, from the result of cases, that the woman has the best chance of recovery, if we are satisfied with obviating symptoms, and removing inflammation in the first instance ; and supporting the strength of the patient through the progress of the disease, should it not prove rapidly fatal ; enjoining rest, giving mild diet, and favouring the expulsion of the bones, by poultices and fomentations, and, if necessary, by enlarging the abscess if it point externally.

#### SECTION THIRTY-FIFTH.

The usual period of utero-gestation is nine months, but the foetus may be expelled much earlier. If the expulsion take place within three months of the natural term, the woman is said to have a premature labour ; if before that time, she is said to miscarry, or have an abortion. The process of abortion consists of two parts, detachment and expulsion ; but these do not always bear a uniform relation to each other in their degree. The first is productive of hemorrhage, the second of pain ; for the one is attended with rupture of

\* Dr Percival's patient attributed her accident to a fright ; Dr Underwood's referred hers to mental agitation.



vessels, the other with contraction of the muscular fibres. The first may exist without being followed by the second, but the second always increases, and ultimately completes the first. The symptoms then of abortion, must be those produced by separation of the ovum, and contraction of the uterus. To these, which are essential, may be added others more accidental, induced by them, and varying according to the constitution and habits of the patient.

The ovum may be thrown off at different stages of its growth; and the symptoms, even at the same period, vary in duration and degree. The process of gestation may be checked, even before the foetus or vesicular part of the ovum has descended into the uterus, and when the decidua only is formed. In this case, which occurs within three weeks after impregnation, the symptoms are much the same with those of menorrhagia. There is always a considerable, and often a copious discharge of blood, which coagulates or forms clots. This is accompanied with marks of uterine irritation, such as pain in the back and loins, frequently spasmodic affections of the bowels, and occasionally a slight febrile state of the system. In plethoric habits, and when abortion proceeds from over-action, or hemorrhagic action of the uterine vessels, the fever is idiopathic, and precedes the discharge. In other circumstances it is either absent, or, when present, it is symptomatic, and still more inconsiderable, arising merely from pain or irritation. As the primary vessels are very small, and are soon displaced, they cannot be detected in the discharge. Nothing but coagulum can be perceived; and this, as in other cases of uterine hemorrhage, is often so firm, and the globules and lymph so disposed, as to give it, more especially if it have been retained for some time about the uterus or vagina, a streaked or fibrous appearance, which sometimes gives rise to a supposition, that it is an organized substance. The discharge does not cease when the primary vessels are destroyed, but generally continues until the small vesicle passes out of the fallopian tube. Then it stops, and an oozing of serous fluid finishes the process.

The only interruption to the discharge in this case of

abortion, proceeds from the formation of clots, which, however, are soon displaced. Women, if plethoric, sometimes suffer considerably from the profusion of the discharge; but, in general, they soon recover.

If the vesicle have descended into the uterus, the symptoms are somewhat different. We have an attempt in the uterus to contract, which formerly was not necessary; we have pains more or less regular in the back and hypogastric region; we have more disturbance of the abdominal viscera, particularly the stomach. The discharge is copious, and small bits of fibrous substance can often be observed. Sometimes the vesicle may be detected in the first discharge of blood, and will be found to be streaked over with pale vessels, giving it an appearance as if it had been slightly macerated. When all the contents are expelled, a bloody discharge continues for a few hours, and is then succeeded by a serous fluid. At this time, and in later abortion, if the symptoms take place gradually, we may sometimes observe a gelatinous matter to come away before the hemorrhage appears.

If the uterus contain more vascular and organized matter, as in the beginning of the third month, the vesicle never escapes first; but we have for some time a discharge of blood, accompanied or succeeded by uterine pain. Then the inferior, part or short stalk of the ovum may be expelled gorged with blood, and afterwards the upper part equally injured. Sometimes the whole comes away at once and entire; but this is rare. As considerable contraction is now required in the uterus, the pains are pretty severe. The derangement of the stomach is also greater than formerly, giving rise to sickness or faintness, which is a natural contrivance for abating the hemorrhage.

When the membranes come to occupy more of the uterus, and a still greater difference exists betwixt the placenta and decidua, we have again a change of the process; we have more bearing-down pain, and greater regularity in its attack; we have a more rapid discharge, owing to the greater size of the vessels; but there is not always more blood lost now than

at an earlier period, for coagula form readily from temporary fits of faintness and other causes, and interrupt the flow until new and increased contraction displaces them. Often the membranes give way, and the foetus escapes with the liquor amnii, whilst the rest of the ovum is retained for some hours or even days\*; when it is expelled with coagulated blood separating and confounding its different parts or layers. At other times the foetal and maternal portions separate, and the first is expelled before the second, forming a very beautiful preparation. In some rare instances we find the whole ovum expelled entire, and in high preservation. After the expulsion, the hemorrhage goes off, and is succeeded by a discharge, somewhat resembling the lochia.

In cases of twins, after one child is expelled, either alone or with its secundines, the discharge sometimes stops, and the woman continues pretty well for some hours, or even for a day or two, when a repetition of the process takes place; and if she has been using any exertion, there is generally a pretty rapid and profuse discharge. This is one reason, amongst many others, for confining women to bed for several days after abortion.

There is frequently, for a longer or shorter time before the commencement of abortion, a pain and irregular action in the neighbouring parts, which give warning of its approach before either discharge or contraction take place†; unless when it proceeds from violence, in which case the discharge may instantly appear. This is the period at which we can most effectually interfere for the prevention of abortion. I need not be particular in adding, that we are not to confound these symptoms with the more chronic ailments which accompany pregnancy.

A great diversity obtains in different instances with regard to the symptoms and duration of abortion. In some cases the pains are very severe and long continued; in others, short

\* In all cases the placenta is retained much longer after the expulsion of the child in abortion, than in labour at the full time.

† In some cases, shooting pains and tension are felt in the breasts before abortion, and the patient is feverish.



and trifling ; nor is the degree of pain always a correct index of the force of contraction. Sometimes the hemorrhage is profuse\* and alarming ; at other times, although circumstances may not be apparently very different, it is moderate or inconsiderable. Often the sympathetic effects on the stomach and bowels are scarcely productive of inconvenience, whilst in a greater number of instances they are very prominent symptoms.

I may only add, that, *cæteris paribus*, we shall find, that the farther the pregnancy is advanced beyond the third month, and the nearer it approaches to the end of the sixth, the less chance is there of abortion being accompanied, but the greater of its being succeeded, by nervous affection.

As there is a diversity in the symptoms, so is there also in the duration of abortion : for, whilst a few hours in many, and not above three days in the majority of cases, is sufficient to complete the process, we find other instances in which it is threatened for a long time, and a number of weeks elapse before the expulsion take place.

In some cases the child appears to be dead for a considerable time before the symptoms which accompany expulsion occur. But in a great majority of cases it is living, when the first signs of abortion are perceived, and in some instances is born alive. The signs by which we judge that the child in utero is dead, are the sudden cessation of the morning sickness, or of any other sympathetic symptom which may have been present. The breasts become flaccid. If milk had been formerly secreted, it sometimes disappears, but in other instances the contrary happens, and no evident secretion takes place until the action of gestation, or at least the life of the child be lost. In almost every case, however, the breasts will be found to have lost their firmness. If the pregnancy had advanced beyond the period of quickening, the motion of the child will be lost, and a feeling of heaviness will be felt about the pelvis. When all these signs are observed, and when they are followed by discharge, and

\* Those who are plethoric generally lose most blood, unless the contraction have been brisk. \* In some cases six or seven pounds of blood have been lost in a few hours.

especially when this is attended with pain, there can be no doubt that expulsion will take place, and it would be improper to prevent it. We are not, however, to conclude that the child is dead, merely because it does not move; and when abortion is threatened before the term of quickening, this sign does not enter into our consideration.

When the ovum perishes at a very early period, and is not immediately discharged, we find that the sympathetic signs of pregnancy disappear, and not unfrequently a serous or milky fluid comes from the nipples. The woman feels languid and hot at night, or has fits of sickness, or hysterical symptoms; a discharge of fœtid dark coloured fluid takes place from the vagina, and is often mixed with particles like snuff. This continues till all the remains of the ovum have come away, and then the health and spirits are restored.

If at a more advanced period, the ovum remains after the child dies, it is converted either into a mole or hydatid; and this may also happen even at a very early stage of pregnancy. These cases have already been considered. It is generally most prudent to obviate symptoms, and wait until the os uteri open and pains come on. Then we are to be directed by existing circumstances. Whether the ovum become putrid, or undergo a change into hydatids, it is reasonable to expect that the vessels of the uterus being no longer employed in the growth of the fœtus should diminish, and become in the first case merely sufficient to nourish the uterus; and, in the second, to supply the necessities of the substance attached to the inner surface of the womb; for there is a communication between them, and a discharge of blood attends the expulsion of either a mole or hydatid; whereas, on the other hand, if the ovum has perished completely and become putrid, the discharge is rather a fœtid sanies than red blood.

Abortion may very properly be divided into accidental and habitual. The exciting causes of the first class may, in general, be easily detected; those giving rise to the second are often more obscure; and, without great attention, the woman will go on to miscarry, until either sterility, or some fatal disease, be induced.

In many cases there can be no peculiar pre-disposing cause of abortion; as, for instance, when it is produced by blows, rupture of the membranes, or accidental separation of the decidua: but when it occurs without any very perceptible exciting cause, it is allowable to infer, that some pre-disposing state exists; and this frequently consists in an imperfect mode of uterine action, induced by age, former miscarriages, and other causes. It is well known, that women can only bear children until a certain age; after which, the uterus is no longer capable of performing the action of gestation, or of performing it properly. Now, it is observable, that this incapability or imperfection takes place sooner in those who are advanced in life before they marry, than in those who have married and begun to bear children earlier. Thus we find, that a woman who marries at forty, shall be very apt to miscarry; whereas, had she married at thirty, she might have born children when older than forty; from which it may be inferred, that the organs of generation lose their power of acting properly sooner, if not employed, than in the connubial state. The same cause which tends to induce abortion at a certain age in those who have remained until that time single, will also, at a period somewhat later, induce it in those who have been younger married; for in them we find, that, after bearing several children, it is not uncommon to conclude with an abortion; or, sometimes after this incomplete action, the uterus, in a considerable time, recruits, as it were, and the woman carries a child to the full time, after which she ceases to conceive.

In the next place, I mention that one abortion paves the way for another; because, setting other circumstances aside, it gives the uterus a tendency to stop its action of gestation at an early period after conception, and therefore it is difficult to make a woman go to the full time, after she has miscarried frequently. This fact has also been explained upon the principle of repeated abortion weakening the uterus\*,

\* *Per hanc vero consuetudinem nihil aliud intelligo, quam pravam vasorum uteri laxitatem et inde provenientem humorum stagnationem, ex abortiendi labore sæpius repetito inductam.* HOFFMAN, Tom. iii. p. 180.



and this certainly may have some influence. The renewed operation of those causes which formerly induced abortion, may likewise account in many cases for its repetition. But I am also inclined to attribute the recurrence, sometimes, to habit alone, by which I understand that tendency which a part has to repeat or continue those modes of acting which it has frequently performed, as we see in many diseases of the stomach and windpipe; spasmodic affections of these and other organs, being apt to return at the same hour, for a long time. With regard to the uterus, one remarkable instance is related by Schulzsius, of a woman, who, in spite of every remedy, miscarried twenty-three times in the third month. In this, and similar cases, slighter causes applied at the period when abortion formerly happened, will be sufficient to induce it, than would be required at another time.

We also find that an excessive or indiscriminate use of venery, either destroys the power of the organs of generation altogether, making the woman barren, or it disposes to abortion, by enfeebling these organs.

Some slight change of structure in part of the uterus, by influencing its actions, may, if it do not prevent conception, interfere with the process of gestation, and produce premature expulsion. If, however, the part affected be very small, and near the os uteri, it is possible for pregnancy to go on to the full time. Indeed, it generally does go on, and the labour, as may be foreseen, will be very tedious; but the operation of cutting the indurated os uteri, which has been proposed, is seldom necessary. I have known one instance, in which a very considerable part of the uterus, I may say almost the whole of it, was found, after delivery, to be extremely hard, and nearly ossified: but this state could not have existed before impregnation took place, for I cannot conceive that so great a proportion of the uterus should have been originally diseased, and yet that conception, and its consequent actions, should take place; but there is less difficulty in supposing, that, during the enlarging of the uterus, the vessels deposited osseous or cartilaginous matter, instead of muscular fibres.

A general weakness of the system, which must affect the actions of the uterus, in common with those of other organs, is likewise to be considered as giving rise to abortion, though not so frequently as was at one time supposed.

A local weakness of the uterus sometimes exists when the general system is not very feeble; or when the constitution is delicate, the uterus may be weaker in proportion than other organs. In this case, it cannot perform its function with the necessary activity and perfection, but is very apt, after a time, to flag. We cannot operate with medicines directly upon the womb, for the purpose of strengthening it, but must act on it by invigorating the general system, and attending to all the other functions. Sea-bathing is of great service; and after impregnation, every exciting cause of abortion must be guarded against. Women of this description are generally pale, of a weakly, flabby habit, and subject to irregular, often to copious, menstruation, or fluor albus. When they conceive, the cold bath, light digestible food, open bowels, and free air, should be enjoined; and if any uneasy sensation be felt about the uterus or back, or the pulse throb, a little blood should be slowly taken away, and the woman keep her room for some days. Bleeding prevents the womb from being oppressed, and it is as necessary to attend to this, as it is to prevent the stomach from being loaded in a dyspeptic patient. But, on the other hand, were we to bleed copiously, we might injure the action of the uterus, and destroy the child.

It has been supposed that abortion might arise from a rigidity of the uterus, which prevented its distension. But the uterus does not distend like a dead part, upon which pressure is applied, but it grows, and therefore I apprehend that an effect is here considered as a primary cause.

The uterus is not only affected by the general conditions of the system, more especially with regard to sensibility, and the state of the blood vessels; but it likewise sympathises with the principal organs, and may undergo changes in consequence of alterations in their state,

Thus we often find that loss of tone, or diminished action

of the stomach, produces amenorrhœa; and it may also on the same principle induce abortion; on the other hand, the action of the uterus may influence that of other viscera, as we see in pulmonary consumption, which is sometimes suspended in its progress during pregnancy; or, if there be any disposition in an organ to disease, frequent abortion, partly by sympathy betwixt the uterus and that organ, and partly by the weakness which it induces, and the general injury which it does to the system at large, may excite the irregular or morbid action of the organ so disposed.

As the action of the uterus is increased during pregnancy, it must require more nervous energy; but the size of the nerves of the uterus is not increased in proportion to the action; we must therefore depend for the increased supply upon the trunks, or larger portion of nervous substance, from which they arise, for we well know that the quantity of energy expended in an organ, does not depend upon the size of the nerve in its substance, but on the trunk which furnishes it. Whenever action is increased in an organ, it must either perish, or the larger nerve must send the branches more energy, for the branches themselves cannot form it, their extremities being only intended for expending it; from which it follows, that in pregnancy there must be more energy sent to the uterus, and less to some other part.

This is the case with all organs whose action is increased, other parts being deprived in proportion as they are supplied, except when irritation raises general action above the natural degree; the consequence of which is, that the power is not sufficient for the action, which becomes irregular, and the system is exhausted, as we see in febrile conditions.

There being increased action of the uterus in gestation, requiring an increased quantity of energy to support it, we find that the system is put *pro tempore* into an artificial state, and obliged either to form more energy, which cannot be so easily done, or to spend less in some other part. Thus the function of nutrition, or the action by which organic matter is deposited, in room of that which is absorbed, often yields, or is lessened, and the person becomes emaciated, or the



stomach has its action diminished, or the bowels, producing costiveness and inflation. If no part give way, and no more energy than usual be formed, gestation cannot go on, or goes on imperfectly. Hence some women have abortion induced by being too vigorous; that is to say, all the organs persist in keeping up their action in perfection and complete degree.

A tendency to abortion also results from a contrary cause, from organs yielding too readily, allowing the uterus to act too easily. In this state it is as liable to go wrong, as the general system is when it is at the highest degree of action, compatible with health; the most trifling cause deranges it. Thus, sometimes, the intestines yield too readily, and become almost torpid, so that a stool can with difficulty be procured. Here costiveness is not a cause of abortion, though it may be blamed. In like manner, the muscular system may yield and become enfeebled; and in this instance debility is accused as the cause of abortion, although it be, indeed, only an effect of too much energy being destined for the uterus. In this case, the woman is always weaker during menstruation and gestation than at other times.

If the neighbouring parts do not accommodate themselves to the changes in the direction of energy, and act in concert with the uterus, their action becomes irregular, and consequently painful. In this case, the uterus may have its just degree of power and action; but other parts may not be able to act so well under the change of circumstances. This is chiefly the case in early gestation, for, by time, the parts come to act better. It often gives rise to unnecessary alarm, being mistaken for a tendency to abortion; but the symptoms are different. The pain is felt chiefly at night, a time at which weakened parts always suffer most; it returns pretty regularly for several weeks, but the uterus continues to enlarge, the breasts to distend, and all things are as they ought to be, if we except the presence of the pain. This may be alleviated by bleeding, and sometimes by anodynes; but can only be cured by time, and avoiding, by means of rest and care, any additional injury to parts already irregu-

lar and ticklish in the performance of their actions. If this be neglected, they will re-act on the uterus at last, and impede its function. It is therefore highly necessary, especially in those disposed to abortion, to pay attention to pains about the back, loins, or pubes; and to insist upon rest, open bowels, and detracting blood, if the state of the vascular system indicate evacuation.

Even although the different organs, both near and remote, may have accommodated themselves to the changes in the uterine action, in the commencement of gestation, the proper balance may yet be lost at a subsequent period; and this is most apt to take place about the end of the third, or beginning of the fourth month, when the uterus is rising out of the pelvis: and hence a greater number of abortions take place at that time than at any other stage of pregnancy. There is from that time, to the period of quickening, a greater susceptibility in the uterus to have its action interrupted, than either before or afterwards; which points out the necessity of redoubling our vigilance in watching against the operation of any of the causes giving rise to abortion from the tenth to the sixteenth week.

If the action of gestation go on under restraint, as, for instance, by a change of position in the uterus, or by its prolapsing too low in the vagina, it is very apt to be accompanied by uneasy feelings, for, whenever any action is constrained, sensation is produced. The woman feels irregular, and pretty sharp pains in the region of the uterus, and from sympathetic irritation both the bladder and rectum may be affected, and occasionally a difficulty is felt in making water, by which a suspicion is raised that retroversion is taking place. Sometimes the cervical vessels in these circumstances yield a little blood, as if abortion were going to happen; but by keeping the patient at rest, and attending to the state of the rectum and bladder, no harm is done; and when the uterus rises out of the pelvis, no farther uneasiness is felt. Occasionally a pretty considerable discharge may take place under these circumstances, if the vascular system be full, or the vessels about the cervix large. But,

by care, gestation will go on; for discharge alone does not indicate that abortion must necessarily happen. It, indeed, often cause; abortion, and is almost always an attendant upon it; but we form our judgment, not from this symptom alone, but also from the state of the muscular fibres, and the vitality of the child.

Retroversion of the uterus likewise constrains very much its action, and may give rise to abortion, though in a greater number of instances, by care, gestation will go on, and the uterus gradually ascend. The bowels are to be kept open, and the urine regularly evacuated.

Sometimes in irritable or hysterical habits, the process of gestation produces a considerable degree of disturbance in the actions of the abdominal viscera, particularly the stomach; exciting frequent and distressing retching or vomiting, which may continue for a week or two, and sometimes is so violent, as to invert the peristaltic motion of the intestines near the stomach, in which case feculent matter, and, in some instances, lumbrici are vomited.

This affection is often accompanied by an unsettled state of mind, which adds greatly to the distress. We sometimes, in these circumstances, have painful attempts made by the muscles to force the uterus downward, and these are occasionally attended by a very slight discharge of blood. We have, however, no regular uterine pain; and, if we are careful of our patient, abortion is rarely produced.

The best practice is to take away a little blood at first, to keep the bowels open, to lessen the tendency to vomit, by applying leeches, or an opium plaster, or a small blister, to the region of the stomach, and to allay pain by doses of hyoscyamus or opium, conjoined with carminatives. When the mind is much affected, or the head painful, it is proper to shave the head, and wash it frequently with cold vinegar, or apply leeches to the temples; at the same time we keep the patient very quiet, and have recourse to a soothing management.

The uterus being a large vascular organ, is obedient to the laws of vascular action, whilst the ovum is more influ-



enced by those regulating new-formed parts; with this difference, however; that new-formed parts or tumors are united firmly to the part from which they grow by all kind of vessels, and generally by fibrous or cellular substance, whilst the ovum is connected to the uterus only by very tender and fragile arteries and veins. If, therefore, more blood be sent to the maternal part of the ovum, than it can easily receive and circulate and act under, rupture of the vessels will take place, and an extravasation and consequent separation be produced; or, even when no rupture is occasioned, the action of the ovum may be so oppressed and disordered, as to unfit it for continuing the process of gestation. There must, therefore, be a perfect correspondence betwixt the uterus and the ovum, not only in growth and vascularity, but in every other circumstance connected with their functions.

Even when they do correspond, if the uterus be plethoric, the ovum must also be full of blood, and rupture is very apt to take place. This is a frequent cause of abortion, more especially in those who menstruate copiously. On the other hand, when the uterus is deficient in vascularity, which often happens in those who menstruate sparingly or painfully, or who have the menses pretty abundant, but watery, the child generally dies before the seventh month, and is expelled. The process is prematurely and imperfectly finished.

The existence of plethora is to be considered as a very frequent cause of abortion, and requires most particular attention. It more especially obtains in the young and vigorous, or in those who live luxuriously, and sleep in soft warm beds. It renders the uterus too easily supplied with blood: the increase is not made in the regular degree, corresponding to the gradual increase of action, and augmentation of size; but it is, if I may use the expression, forced on the uterus, which is thus made for a time to act strongly and rapidly. This action is sometimes so great, that the person feels weight in the region of the uterus, and shooting pains about the pelvis; but, in other instances, the vessels suddenly gives way, without previous warning, and the blood bursts forth at the

os uteri. This cause is especially apt to operate in those who are newly married, and who are of a salacious disposition, as the action of the uterus is thus much increased, and the existence of plethora rendered doubly dangerous. In these cases, whenever the menses have become obstructed, all causes tending to increase the circulation must be avoided, and often a temporary separation from the husband is indispensable. Often do we find that slight exertion, within a fortnight after the menses stop, will produce a speedy and violent eruption of blood, which continues until the vessels are fully unloaded, and until all that part of the process of forming an ovum, which has been effected, be undone.

Abortion necessarily implies separation of the ovum, which may be produced mechanically, or by spontaneous rupture of the vessels, or by an affection of the muscular fibres. It unavoidably requires, for its accomplishment, contraction of those fibres which formerly were in a dormant state. A natural and necessary effect of this contraction is to develop the cervix uteri. This, when gestation goes on regularly, is accomplished gradually and slowly by the extension and formation of fibres. In abortion, no fibres are formed; but muscular action does all, except in those instances where the action of gestation goes on irregularly and too fast; in which case the cervix distends, sometimes by the third month, by the same process which distends the fundus. But much more frequently the cervix only relaxes during abortion, as the os uteri does in natural labour, and yields to the muscular action of the fundus, or distended part.

The existence and growth of the foetus depend on the foetal portion of the ovum. The means of nourishment, and the accommodation of the foetus in respect of lodgment, depend on the uterus; and these circumstances requiring both foetal and maternal action, are intimately connected. The condition of the uterus qualifying it to enlarge, to continue the existence and operation of the maternal portion of the placenta or ovum, and to transmit blood to the ovum, exactly in the degree correspondent to its want, constitutes the action of gestation. When the action of gestation ceases

universally in the uterus, another action, namely, muscular contraction, begins, and then all hope of retaining the ovum any longer is at an end. I know that we have been told of instances where contraction, after beginning, stopped for several weeks. The os uteri may be prematurely developed; it may be open for some weeks, even without pain; but no man will say that, in this case, labour or uterine contraction has begun. We may even have partial muscular action, in a few cases, about the os uteri, which has less to do with the action of gestation than any other part of the uterus; and this action is often attended with considerable pain or uneasiness. Sometimes it is connected with convulsive agitation of several of the external muscles of the body. Even in this case, expulsion does not always immediately take place; for by bleeding, and rest, and opiates, the motion may sometimes be checked; but regular and universal action of the muscular fibres never yet has been stopped. It may, like other muscular actions, be suspended by anodynes or artificial treatment; but it never has, and never can be stopped, otherwise than by the expulsion of the ovum, when a new train of actions commence. Whenever, then, at any period of pregnancy, we have paroxysms of pain in the back\*, and region of the uterus, more especially if these be attended with feeling of weight in that region, tenesmus, micturition, descent of the uterus in the pelvis, and opening of the os uteri, we may be sure that expulsion, though retarded, will soon take place. This fact is not always attended to in abortion, for many think that if by anodynes they can abate the pain, they will make the woman go to the full time.—This is true, with regard to many painful sensations, which

\* It may not be improper to mention, that in some febrile affections we have pain in the back and loins, occasionally remitting, or disappearing altogether for a short space, and then returning. Sometimes along with this we have, owing to the affection of the circulation, and in some instances to previous exertion, a slight discharge from the vessel about the os uteri. This state is distinguished from uterine contraction, by our finding that the cervix is unaffected, that the pains are increased by motion or pressure, and are more irregular than those attending labour. This state may be prevented from inducing abortion, by rest, by keeping the bowels open, by anodynes preceded by venesection, if the pulse indicate it. Friction, with camphorated spirits of wine or laudium, give relief. Any exertion, during the remaining period of gestation, will renew the pain in the back.



may attend a threatened abortion, or which may be present, although there be no appearance of abortion ; but it does not hold with regard to those regular pains proceeding from universal action of the uterine fibres ; and we may save both ourselves and our patients some trouble, by keeping this in remembrance.

Seeing, then, that contraction is brought on by stopping the action of gestation, and that when it is brought on it cannot be checked, nor the action of gestation restored, we must next inquire how this action may be stopped. I have already mentioned several circumstances affecting the uterus, and likely to injure its actions ; and these I shall not repeat, but go on to notice some others, which are often more perceptible : and first I shall mention violence, such as falls, blows, and much fatigue, which may injure the child, and detach part of the ovum. If part of the ovum be detached, we have not only a discharge of blood, but also the uterus, at that part, suffers in its action, and may influence the whole organ, so as to stop the action universally. But the time required to do this is various, and opportunity is often given to prevent the mischief from spreading, and to stop any farther effusion—perhaps to accomplish a re-union.

Violent exercise, as dancing, for instance, or much walking, or the fatiguing dissipations of fashionable life, more especially in the earlier months, by affecting the circulation, may vary the distribution of blood in the uterus, so much as to produce rupture of the vessels, or otherwise to destroy the ovum. There is also another way in which fatigue acts, namely, by subducting action and energy from the uterus : for the more energy that is expended on the muscles of the inferior extremities, the less can be afforded or directed to the uterus ; and hence abortion may be induced at an early stage of gestation \*. Even at a more advanced period, inconvenience will be produced upon the principle formerly mentioned ; for the nerves of the loins conveying less energy, in many instances, though not always, to the muscles, they

\* The same effect is observable in the stomach and other organs. If a delicate person, after a hearty meal, use exercise to the extent of fatigue, he feels that the food is not digested, the stomach having been weakened or injured in its actions.

are really weaker than formerly, and are sooner wearied, producing pain, and prolonged feeling of fatigue for many days, after an exertion which may be considered as moderate. This feeling must not be confounded with a tendency to abortion, though it may sometimes be combined with it, for generally by rest the sensation goes off. Neither must we suppose that the child is dead, from its being usually quiet during that period, for as soon as the uterus, which has been a little impaired in its action, recovers, it moves as strongly as ever.

In the next place, I mention the death of the child, which may be produced by syphilis, or by diseases perhaps peculiar to itself, or by that state which produces too much liquor amnii, or by injury of the functions of the placenta, which may arise from an improper structure of the gland itself, or aneurism, or other diseases of the cord. But in whatever way it is produced, the effect is the same in checking the action of gestation, unless there be twins, in which case it has been known, that the uterus sometimes did not suffer universally; but the action went on, and the one child was born of the full size, the other small and injured\*. The length of time required for producing abortion from this cause is various; sometimes it is brought on in a few hours; at other times not for a fortnight, or even longer. In these and similar cases, when the muscular action is commencing, the discharge is trifling, like menstruation, until the contraction becomes greater, and more of the ovum be separated. When symptoms of abortion proceed from this cause, it is not possible to prevent its completion; and it would be hurtful even if it were possible. When, therefore, after great fatigue, profuse evacuations in delicate habits, violent colic, or other causes, the motion of the child ceases, the breasts become flaccid, and the signs of gestation disappear, we need not attempt to re-

\* It has even been known, that, in consequence of the death of one child, the uterus has suffered partially, and expulsion taken place; but the other child continuing to live, has preserved the action of gestation in that part of the uterus, which, properly speaking, belonged to it, and pregnancy has still gone on. This, however, is an extremely rare occurrence; for in almost every instance, the death of one child produces an affection of the action of gestation in the whole uterus, and the consequent expulsion of both children.

tard expulsion, but should direct our principal attention to conduct the woman safely through the process.

Another cause is, any strong passion of the mind. The influence of fear, joy, and other emotions on the muscular system, is well known; and the uterus is not exempted from their power; any sudden shock, even of the body, has much effect on this organ. The pulling of a tooth, for instance, sometimes suddenly produces abortion.

Emmenagogues, or acrid substances, such as savine and other irritating drugs, more especially those which tend to excite a considerable degree of vascular action, may produce abortion.

Such medicines, likewise, as exert a violent action on the stomach or bowels will, upon the principle formerly mentioned, frequently excite abortion; and very often are taken designedly for that purpose in such quantity as to produce fatal effects\*; hence emetics, strong purgatives, diuretics, or a full course of mercury, must be avoided during pregnancy.

If any part with which the uterus sympathizes have its action greatly increased during pregnancy, the uterus may come to suffer, and abortion be produced. Hence the accession of morbid action or inflammation in any important organ, or on a large extent of cuticular surface, may bring on miscarriage, which is one cause why small-pox often excites abortion, whilst the same degree of fever, unaccompanied with eruption, would not have had that effect. Hence also in-

\* It is an old observation, that those purgatives, which produce much tenesmus, will excite abortion; and this is certainly true, if their operation be carried to a considerable extent, and continue long violent. Hence dysentery is also apt to bring on a miscarriage. Those strong purges which are sometimes taken to promote premature expulsion, not only act by exciting tenesmus, but likewise by inflaming the stomach and bowels, and thus affect the uterus in two ways. It cannot be too generally known, that when these medicines do produce abortion, the mother can seldom survive their effect. It is a mistaken notion, that abortion can be most readily excited by drastic purges, frequent and copious bleeding, &c. immediately after the woman discovers herself to be pregnant; on the contrary, the action of the uterus is then more independant of that of other organs, and therefore not so easily injured by changes in their condition. I have already shewn, that abortion more frequently happens when the pregnancy is farther advanced, because then not only the uterus is more easily affected, but the fœtus seems to suffer more readily. It is apt, either from diseases directly affecting itself, or from changes in the uterine action, to die about the middle of the third month, in which case expulsion follows within a fortnight.



creased secretory action in the vagina, if to a great degree, though it may have even originally been excited in consequence of sympathy with the uterus, may come to incapacitate the uterus for going on with its actions, and therefore it ought to be moderated by means of an astringent injection.

Mechanical irritation of the os uteri, or attempts to dilate it prematurely, will also be apt to bring on muscular contraction. At the same time, it is worthy of remark, that the effect of such irritation is generally at first confined to the spot on which it acts, a partial affection of the fibres in the immediate vicinity of the os uteri being all that is, for some time, produced; and therefore slight uneasiness at the lower part of the belly, with or without a tendency in the os uteri to move or dilate, whether brought on by irritation at the upper part of the vagina or os uteri, or by affection of the neck of the bladder, &c. may be often prevented from extending farther, by rest, anodynes, and having immediate recourse to such means as the nature of the irritation may require for its removal\*.

The irritation of a prolapsus ani, or of inflamed piles, with or without much sanguineous discharge, may excite the uterus to contract; and if the bleeding from the anus have been profuse, and the woman weakly, it may destroy the child. The piles ought, therefore, never to be neglected.

Tapping the ovum, by which the uterus collapses and its fibres receive a stimulus to action, is another cause by which abortion may be produced; and this is sometimes, with great propriety, done at a particular period, in order to avoid a greater evil. It is now the general opinion, that contraction will unavoidably follow the evacuation of the waters. But we can suppose the action of gestation to be in some cases so strong as not, at least for a very considerable time, to stop in consequence of this violence, and, if it do not stop, contraction will not take place. I do not, however, mean to say, that all discharges of watery fluid from

\* Chronic inflammation of the heart is generally attended with pain at the bottom of the abdomen, which is sometimes mistaken for symptoms of calculus. In one case abortion seemed to proceed from this disease of the heart.

the uterus, not followed by abortion, are discharges of the liquor amnii. On the contrary, I know, that most of these are the consequence of morbid action about the os uteri, the glands yielding a serous, instead of a gelatinous fluid, and this action may continue for many months.

In all these cases, the woman must be confined to bed, and have an anodyne every night at bed-time, for some time, premising venesection if the pulse indicate it, and conjoining gentle laxatives. There is just so much probability of gestation going on as to encourage us to use endeavours to continue it. In those instances where the discharge is small, and the oozing pretty constant, we conclude that it is yielded chiefly by the glands about the os uteri, and may derive advantage from injecting three or four times a-day a strong infusion of galls, or solution of alum. The woman ought to use no exertion, as the membranes are apt to give way.

It is sometimes necessary to lay down rules for the management of pregnant women, even although they may not have been liable to abortion. These are to be drawn from the remarks already delivered, and it is only requisite to add, that in all cases it is proper to attend to the effects of uterogestation, or the diseases of pregnancy, which are to be mitigated when severe by suitable remedies.

The danger of abortion is to be estimated by considering the previous state of the health, by attending to the violence of the discharge, and the difficulty of checking it; to its duration, and the disposition to expulsion which accompanies it; to the effects which it has produced in weakening the system, and to its combination with hysterial or spasmodic affections. In general, we say that abortion is not dangerous, yet in some cases it does prove fatal very speedily, either from loss of blood, or spasm of the stomach, or convulsions. It is satisfactory, however, to know, that this termination is rare, that these dangerous attendants are seldom present, and that a great hemorrhage may be sustained, and yet the strength soon recover. But if there be any disposition in a particular organ to disease, abortion may make it active, and thus, at a remote period, carry off the patient. Mis-

carriages, if frequently repeated, are also very apt to injure the health, and break up the constitution.

When abortion is threatened, the process is very apt to go on to completion; and it is only by interposing, before the expulsive efforts are begun, that we can be successful in preventing it; for whenever the muscular contraction is universally established, marked by regular pains, and attempts to distend the cervix and os uteri, nothing, I believe, can check the process. As this is often the case before we are called, or, as in many instances abortion depends on the action of gestation being stopped by causes, whose action could not be ascertained until the effect be produced, we shall frequently fail in preventing expulsion.

This is greatly owing to our not being called until abortion, that is to say, the expulsive process has begun; whereas, had we been applied to upon the first unusual feeling, it might have been prevented. What I wish then particularly to inculcate is, that no time be lost in giving notice of any ground of alarm, and that the most prompt measures be had recourse to in the very beginning; for, when universal uterine contraction has commenced, then all that we can do is to conduct the patient safely through a confinement, which the power of medicine cannot prevent.

The case of threatened abortion, in which we most frequently succeed, is that arising from slipping of the foot, or from causes exciting a temporary over-action of the vessels, producing a slight separation; because here the hemorrhage immediately gives alarm, and we are called before the action of gestation be much affected. Could we impress upon our patients the necessity of equal attention to other preceding symptoms and circumstances, we might succeed in many cases where we fail from a delay, occasioned by their not understanding that an expulsion can only be prevented, by interfering before that process begins; for when sensible signs of contraction appear, the mischief has proceeded too far to be checked. Prompt and decided means used upon the first approach of symptoms indicating a hazardous state of the uterus, or on the earliest appearance of hemorrhage may, provided the child be still alive, be attended with success.



In considering the treatment, I shall first of all notice the most likely method of preventing abortion in those who are subject to it; next, the best means of checking it, when it is immediately threatened; and, lastly, the proper method of conducting the woman through it, when it cannot be avoided.

The means to be followed in preventing what may be called habitual miscarriage, must depend on the cause supposed to give rise to it. It will, therefore, be necessary to attend to the history of former abortions; to the usual habits and constitution of the woman; and to her condition when she becomes pregnant.

In many instances a plethoric disposition, indicated by a pretty full habit, and copious menstruation, will be found to give rise to it. In these cases, we shall find it of advantage to restrict the patient almost entirely to a vegetable diet, and, at the same time, make her use considerable and regular exercise.

The sleep should be abridged in quantity, and taken, not on a bed of down, but on a firm mattress, at the same time that we prevent the accumulation of too much heat about the body. The bowels ought to be kept open, or rather loose, which may be effected by drinking Cheltenham water, or taking some other laxative. We must not, however, carry this plan too far, nor make a sudden revolution in the constitution, as this may be productive of permanent mischief, and occasion the diseases which proceed from a broken habit. Whenever the strength is diminished, the appetite impaired, or any other bad effect is produced, we have gone too great length.

There is, in plethoric habits, a weakness of many, if not all of the functions; but this is not to be cured by tonics, but by continued and very gradually increased exercise, laxatives, and light diet, consisting chiefly of vegetables. This plan, however, must not be carried to an imprudent length, nor established too suddenly; but regard is to be had to the previous habits. It is a general rule, that exercise should not be carried the length of fatigue, and that it should be taken, if possible, in the country; whilst late hours,

and many of the modes of fashionable life, must be departed from. We may also derive so considerable advantage from conjoining with this plan, the shower bath or sea-bathing, that they ought not to be omitted. There is, I believe, no remedy more powerful in preventing abortion than the cold bath, and the best time for using it is in the morning. By means of this, conjoined with attention to the vascular system, and prudent conduct on the part of the patient, I suppose that nine-tenths of those who are subject to abortion, may go on to the full time. If the shower-bath be employed, we must begin with a small quantity of water; and, in some instances, may at first add so much warm water as shall make it just feel cold, but not to give too great a shock. If the cold bath cause headach, this may often be prevented by premising one or two doses of physic.

After conception, the exercise must be taken with circumspection: but the diet should still be sparing, and the use of the cold bath continued. If the pulse be at any time full, or inclined to throb, or if the patient be of a vigorous habit, a little blood should be taken away at a very early period. In some cases where the action is great, we must bleed almost immediately after the suppression of the menses. It is not necessary to bleed copiously; it is much better to take away only a few ounces, and repeat the evacuation when required, and we should manage so as to avoid fainting. The cold bath should be conjoined, and we may derive advantage by using the digitalis \*, so as slightly to affect the pulse, keeping it at or below its natural frequency, and to diminish its throbbing. But it is not requisite to be given to the degree employed in some other complaints; and, if it be pushed to an imprudent length, the child may suffer. Half a grain may be given, twice or thrice a-day. It may be continued for two days, and then omitted for a day; and in this way it may be continued till the danger is past. In those cases where the digitalis produces feebleness, it is evidently improper to con-

\* The acetite of lead has been recommended by the ingenious and justly celebrated Dr Rush of Philadelphia, in doses of from one to three grains, given three times a-day. Of this practice I cannot speak from my own experience; but Dr Rush informs me, that in his hands it has been attended with great success.

tinue it regularly. Indeed, when this effect takes place, its farther exhibition is unnecessary. It is also improper where it acts powerfully on the kidneys. By attending to these cautions, it may, in cases requiring it, be continued with occasional omissions of a day or two, even for some weeks, but it is very seldom necessary to persist in it above a fortnight at most.

Injecting cold water into the vagina, twice or thrice a-day, has often a good effect, at the same time that we continue the shower-bath every morning. When there is much aching pain in the back, it is of service to apply cloths to it, dipped in cold water, or gently to dash cold water on it; or employ a partial shower-bath, by means of a small watering can.

In this, and all other cases of habitual abortion, we must advise, that impregnation shall not take place until we have corrected the system; and after the woman has conceived, it is requisite that she live *absque marito*, at least until gestation be far advanced. I need scarcely add, that when consulted respecting habitual abortion, the strictest prudence is required on our part, and that the situation of the patient, and many of our advices, should be concealed from the most intimate friends of the patient.

In other cases, we find that the cause of abortion is connected with sparing menstruation. This is often the case with women whose appearance indicates good health, and who have a robust look. This is not often to be rectified by medicine, but it may by regimen, &c. Here, as in the former case, we find it useful to make the greatest part of the diet consist of vegetables; but it is not necessary to restrict the quantity.

When, on the other hand, the patient has a weakly delicate appearance, it will be proper to give a greater proportion of animal food, and two or three glasses of wine, in the afternoon, with some bitter laxative, twice a-day, so as to strengthen the stomach, and at the same time keep the bowels open.

We also derive, in both cases, advantage from the daily use of the warm bath, made of a pleasant temperature; but



this is to be omitted after conception ; at least, for the first ten or twelve weeks: after which, if there be symptoms of irritation, or feeling of tension about the belly, or pain about the groins, or pubis, it may be employed, and is both safe and advantageous. But when the patient is of a phlegmatic habit, or subject to profuse fluor albus, it is not indicated, and sometimes is pernicious. The internal use of the bath waters previous to conception is often of service ; or where the circumstances of the patient will not permit this, we may desire her to drink, morning and evening, a pint of tepid water, containing half a dram of sweet spirit of nitre. Throwing up into the vagina tepid salt-water twice or thrice a day, seems also to have a good effect.

I have already mentioned, that abortion is sometimes the consequence of too firm action, the different organs refusing to yield to the uterus, which is thus prevented from enjoying the due quantity of energy and action. These women have none of the diseases of pregnancy, or they have them in a slight degree. They have good health at all times, but they either miscarry, or have labour in the seventh or eighth month, the child being dead ; or, if they go to the full time, I have often observed the child to be sickly, and of a constitution unfitting it for living. Blood-letting is useful by making the organs more irritable. The tepid bath is in general of advantage, and may be employed every second evening for some time.

There is another case in which all the functions are healthy and firm, except the circulation, which is accelerated by the uterine irritation. This is more or less the case in every pregnancy ; but here it is a prominent symptom. The woman is very restless, and even feverish, and apt to miscarry, especially if she be of a full habit. Immediate relief is given by venesection ; and afterwards we may, for some time, give every night half a grain or a grain of digitalis, with two grains of the extract of hyocyamus.

When, on the contrary, abortion arises from too easy yielding of some organ, we must keep down uterine action, by avoiding venery, and injecting cold water often into the

vagina, or pouring cold water every morning from a watering can, upon the loins and ilia; at the same time we must attend to the organ sympathising with the uterus.

Sometimes it is the stomach which is irritable, and the person is often very sick, takes little food, and digests ill. A small blister, or leeches, applied to the pit of the stomach, often relieves this; a little of the compound tincture of bark, taken three or four times a-day, is serviceable; or a few drops of the tincture of muriated iron, in a tumbler glassful of aerated water. At other times, the bowels yield, and the patient is obstinately costive. This is cured by aloetic pills, or manna, with the tartarite of potash. When the muscular system yields, producing a feeling of languor and general weakness, the use of the cold bath, with a grain of opium at bed-time, will be of most service.

It is evident, that it is only by attending minutely to the history of former miscarriages, that we can detect these causes; and we shall generally find, that in each individual case, it is the same organ in every pregnancy which has yielded or suffered. Previous to future conception, we may, with propriety, endeavour to render it less easily affected.

General weakness is another condition giving rise to abortion; and upon this I have already made some remarks. I have here only to add, that the use of the cold bath, the exhibition of the Peruvian bark, and wearing flannel next the skin, constitute the most successful practice.

Syphilis is likewise a cause of abortion. When it occurs in the mother, it often unfits the uterus for going on with its actions. At other times, more especially when the father labours under venereal hectic, or has not been completely cured, the child is evidently affected, and often dies before the process of gestation can be completed. In these cases, a course of mercury alone can effect a cure. But we are not to suppose that every child, born without the cuticle in an early stage of pregnancy, has suffered from this cause; on the contrary, as some of these instances depend on causes already mentioned, and which cannot be cured by mercury, I wish to caution the student against too hastily

concluding that one of the parents has been diseased, because the child is born dead or putrid at an early period. It is not always easy to form a correct judgment; but we may be assisted by finding that the other causes which I have mentioned are absent; that we have appearances of ulceration on the child, and that there are some suspicious circumstances in the former history and present health of the parents. A child may be born dead, and even putrid, not only in consequence of syphilis, but also of some malformation of the foetus itself, or of its appendages; or of a general imperfection of the ovum, usually combined with an increased quantity of liquor amnii; or of original debility of constitution, unfitting the child for coming to maturity; or of fatal derangement of structure, or action taking place in utero, from causes often not very obvious; or from weakness or imperfect action of the uterus itself, or such a condition of it as sometimes produces epilepsy; or it is in certain cases occasioned by a convulsion. Most of these causes are not under our controul; and indeed, with the exception of the case of syphilis we can only propose to prevent the death of the child, by the use of such general means as invigorate the constitution of the parent, or as obviate palpable predisposing causes of injury to the uterine functions.

Advancement in life, before marriage, is another cause of frequent abortion, the uterus being then somewhat imperfect in its action. In general, we cannot do much in this case, except avoiding carefully the exciting causes of abortion; and by attending minutely to the condition of other organs, during menstruation or pregnancy, we may, from the principles formerly laid down, do some good.

It is satisfactory to know, that although we may fail once or twice, yet, by great care, the uterus comes at last to act more perfectly, and the woman bears children at the full time.

After these observations, it is only necessary to add, that in every instance of habitual abortion, whatever the condition may be which give rise to it, we find it is essential that the greatest attention be paid to the avoiding of the



more evident and immediate exciting causes of miscarriage, such as fatigue, dancing, &c. In some cases, it may even be necessary to confine the patient to her room, until the period at which she usually aborts is past.

When abortion is threatened, we come to consider whether, and by what means it can be stopped. I have already stated my opinion, that when the action of gestation ceases, it cannot be renewed, and that general contraction of the uterine fibres is a criterion of this cessation.

Still, as some of the means which may be supposed useful in preventing a threatened abortion, are also useful in moderating the symptoms attending its progress, we may very properly have recourse to them. Some causes giving rise to abortion, do not immediately produce it, but give warning of their operation, producing uneasiness in the vicinity of the uterus, before the action of that organ be materially affected. The detraction of a little blood at this time, if the pulse be in any measure full or frequent, or, if the patient be not of a habit forbidding evacuations, and the subsequent exhibition of an anodyne clyster, or a full dose of opium\*, together with a state of absolute rest in a recumbent posture for some days, will often be sufficient to prevent farther mischief, and constitute the most efficacious practice. The patient should be strictly confined to bed, sleeping with few bed-clothes, and without a fire in her apartments. Indeed, the very first thing to be done on entering the room, is to order the patient to bed. The diet should, in general, be low, consisting of dry toast, biscuit and fruit; and much fluid, especially warm fluid, should be avoided.

This is the time at which we can interfere with the most certain prospect of success; and the greatest attention should be paid to the state of the rest of the system; removing uneasiness, wherever it is present, and preventing any organ from continuing in a state of undue action. It is difficult to persuade the patient to comply with that strict attention which is necessary at this period; but being persuaded that

\* Opiates are of signal benefit in this situation, and should seldom be omitted after venesection.

if this period be allowed to pass over with neglect, and contraction begins, nothing can afterwards prevent abortion, I wish particularly to impress the mind of the student with a due sense of its importance; and I must add, that as after every appearance of morbid uterine action is over, the slightest cause will renew our alarm, it is necessary great attention be paid for some time to the patient.

Often, instead of an uneasy feeling about the loins, or lower belly, we have, before the action of gestation stops, a discharge of blood, generally in a moderate, sometimes in a trifling degree. This is more especially the case when abortion is threatened, owing to an external cause; and, if immediately checked, we may prevent contraction from beginning.

Even in those cases where we do not expect to ward off expulsion, it is useful to prevent, as far as we can, the loss of blood; for as I cannot see that the hemorrhage is necessary for its accomplishment, although it always attends it, I conclude that our attempts to prevent bleeding can never do harm; if they succeed in checking abortion, we gain our object; if they fail, they do not increase, but diminish the danger.

It should be carefully remembered, that the more we can save blood, the more do we serve our patient. As the means for checking the discharge will be immediately pointed out, it is unnecessary here to enter into any detail.

Sometimes the vessels about the cervix and os uteri yield, post coitum, a little blood; and this may occur either in those who have the uterus in a high state of activity, or more frequently where it is feeble in its functions. The same discharge may sometimes appear in rather greater quantity after impregnation, passing perhaps for the menses, and making the woman uncertain as to her situation; but it is generally, though not always, irregular in its appearance, and seldom returns above once or twice. In some instances, however, it becomes greater and more frequent in proportion as the vessels increase in size. It is now apt to pass for menorrhagia. If it be allowed to continue, it tends to

injure the action of the uterus, and produces expulsion, which sometimes is the first thing which shews the woman her situation. The discharge is best managed by rest, and the frequent injection of saturated solution of the sulphate of alumine, or decoction of oak bark.

When a slight discharge takes place, in consequence of a slip of the foot, or some other external cause, we may also derive advantage from the use of the injection; but if the discharge be considerable, it will often fail. It is better, in such a case, to trust to the formation of a coagulum.

When in a plethoric habit abortion is threatened, from a fright, or mental agitation, we have often palpitation, rapidity of the pulse, head-ach, flushed face, and pain about the back or pubis; blood-letting relieves immediately the uneasiness in the head, and often the pain in the back; afterwards, the patient is to be kept cool and quiet, and an anodyne administered.

In those cases, where regular uterine pain precedes or accompanies the discharge, expulsion cannot be prevented; but when the discharge precedes the pain, it sometimes may; nay, if the child be still alive, it frequently may. Rest is absolutely necessary, if we wish the person to go to the full time: and it is occasionally necessary to confine her to bed for several weeks, prescribe the prudent and occasional use of digitalis, and give an anodyne at bed-time, taking care also to keep the bowels in a proper state by gentle medicine. Blood ought also, unless the pulse and habit of the patient forbid it, to be detracted. Styptic injections into the vagina two or three times a-day are of great benefit.

This is a very critical situation: much depends on the vigour and promptitude of our practice; and much, very much, upon the prudence of the patient. It is teasing to find, that sometimes, after all our care and exertions, one rash act destroys in a single day the effect of the whole.

When we cannot prevent abortion, the next thing is to conduct the patient safely through the process, by lessening the effects of separation or detachment of the ovum, and accelerating the contraction. The first point which naturally



claims our attention is the hemorrhage. Many practitioners, upon a general principle, bleed, in order to check this, and prevent miscarriage; but miscarriage cannot be prevented, if the uterine contraction have universally commenced; and the discharge cannot be prudently moderated by venesection, unless there be undue or strong action in the vessels, or much blood in the system; and if so, a vein may be opened with advantage. This is not always the case, and therefore, unless the vessels be at or above the natural force or strength of action, the lancet is not at this stage necessary. The fullness and strength of the pulse are lost much sooner in abortion than can be explained, by the mere loss of blood. This depends on an affection of the stomach, which has much influence on the pulse; and the proper time for bleeding is before this has taken place. When abortion has made so much progress before we are called, as to have rendered the pulse small and feeble; or when this is the case from the first, bleeding evidently can do no good. Instead of this, we may rather use the digitalis, but in ordinary cases, where the contraction is brisk, and the process quick, it is not at this stage absolutely necessary; and I shall afterwards mention that, when the stomachic affection is urgent, and the pulse much affected by it, the use of this medicine is improper. When, however, the case is tedious, and the discharge long continued, at the same time that the sickness is not considerable, the digitalis will be of essential service, and it may be very properly combined with the sulphuric acid. Nauseating doses of emetic medicines act in the same way with the digitalis, but are much less effectual, and more disagreeable, as well as uncertain in their operation. Internal astringents have been proposed, but they have no effect, unless they excite sickness, which is a different operation from that which is expected from them.

The application of cloths dipped in cold water to the back and external parts will have a much better effect than internal astringents, and ought always to be had recourse to. If the digitalis have been exhibited, it assists that medicine in moderating the circulation. Even when trusted to alone.

it lessens the action of the sanguiferous system, particularly of the uterine vessels. The introduction of a small piece of smooth ice into the vagina has been recommended, and has often a very speedy effect in retarding the hemorrhage, whilst it never, if properly managed, does any harm. A small snow-ball, wrapped in a bit of linen, will have the same effect; but neither of these must be continued so long as to produce pain, or much and prolonged shivering. The heat of the surface is also to be moderated, by having few bed-clothes, and a free circulation of cool air.

But the most effectual local method of stopping the hemorrhage is by plugging the vagina. This is best done by taking a pretty large piece of soft cloth, and dipping it in oil, and then wringing it gently. It is to be introduced with the finger, portion after portion, until the lower part of the vagina be well filled. The remainder is then to be pressed firmly on the orifice. This acts by giving the effused blood time to coagulate. It gives no pain; it produces no irritation; and those who condemn it, surely must either not have tried it, or have misapplied it. If we believe that abortion requires for its completion a continued flow of blood, we ought not, in those cases where the process must go on, to have recourse to cold, or other means of restraining hemorrhage. If we do not believe this, then surely the most effectual method of moderating it is the best. Plugging can never retard the process, nor prevent the expulsion of the ovum; for when the uterus contracts, it sends it down into the clotted blood in the upper part of the vagina, and the flooding ceases.

Faintness operates also in many cases, by allowing coagula to form, in consequence of the blood flowing more slowly; and, when the faintness goes off, the coagula still restrain the hemorrhage in the same way as when the plug has been used. This naturally points out the advantage of using the plug, together with the digitalis, as we thus produce coagulation at the mouths of the vessels, and also diminish the vascular action. It will likewise shew the impropriety of using injections at this time; for, by washing out the coagu-

la; we do more harm than can be compensated by any astringent effect produced on the vessels.

The principal means, then, which we employ for restraining the hemorrhage, are bleeding, if the pulse be full and sharp; if not, we trust to the digitalis, combined with sulphuric acid, except in those cases already specified, as forbidding its use, to stuffing the vagina, to the application of cold to the external parts, keeping the heat of the body in general at a low temperature, and enforcing a state of absolute rest, which must be continued during the whole process, however long it may, in some cases, be. The drink should be cold, and the food, if the patient desire any, light, and taken in small portions:

Opiates have been advised, in order to abate the discharge, and are, by many, used in every case of abortion, and in every stage. But as we cannot finish the process without muscular contraction, and as they tend to suspend that, I do not see that their constant exhibition can be defended on rational principles. If given in small quantity, they do no good in the present point of view; if in larger doses, they only postpone the evil, for they cannot check abortion after contraction has begun. But I will not argue against the use of opiates from their abuse. They are very useful in cases of threatened abortion, more especially in accidental separation of the membranes and consequent discharge. They do not directly preserve the action of gestation, but they prevent the tendency to muscular contraction, and thus do good. In weakly or emaciated habits, opiates alone, if given upon the first appearance of mischief, are often sufficient to prevent abortion; and, in opposite conditions, when preceded by venesection, they are of great service. Opiates are likewise useful for allaying those sympathetic pains about the bowels, and many of the nervous affections which precede or accompany abortion. They are also of much benefit in cases where we have considerable and protracted discharge, with trifling pains, as the uterus is not contracting sufficiently to expel the ovum, but merely to separate vessels, and excite hemorrhagia. By suspending for a time its action, it returns after-



wards with more vigour and perfection, and finishes the process. But when the process is going on regularly, opiates will only tend to interfere with it, and prolong the complaint.

It was, at one time, a very frequent practice to endeavour, with the finger or small forceps, to extract the foetus and placenta, in order to stop the discharge. Puzos strongly opposed this practice, and it is now very properly given up as a general rule. I do not wish, however, to be understood as altogether forbidding manual assistance; but I am much inclined to consider it as a useful precept, not to be hasty in attempting to extract the ovum. If the discharge be protracted, and the membranes entire, we may, if the situation of the patient require it, sometimes accelerate expulsion, by evacuating the liquor amnii. But if the pregnancy be not advanced beyond the fourth month, it will be better to trust to smart clysters, and restrain the hemorrhage by means of the plug. We thus have a greater likelihood of getting all the ovum off at once, and may excite the action by gently dilating the os uteri, and moving the finger round it. If the membranes have given way, and the foetus be still retained, we may, by insinuating a finger within the uterus cautiously, hook it out; or, in many cases, it will be found partly expelled through the os uteri, and may easily be helped away. But the most tedious and troublesome case generally is that in which the foetus has been expelled, but the secundines are still retained. Now, we never can consider the patient as secure from hemorrhage until these be thrown off, and therefore she must be carefully watched, especially when gestation is considerably advanced. In a great majority of instances, the uterus, within a few hours, contracts and expels them. But in some cases, the hemorrhage does become profuse, and there is little disposition to separate them. By stuffing the vagina, we shall often find that the discharge is safely stopped, and the womb excited to act in a short time. But if we be disappointed, or the symptoms urgent, the finger must be introduced within the uterus\*, and the remains of the o-

\* In some instances, the half of the secundines will be found in the vagina, and the other half still in the uterus. In this case, all that is necessary is gently to bring them out.

vum slowly detached by very gentle motion ; and we must be very careful not do endeavour to pull away the secundines until they be fully loosened, for we thus leave part behind, which sometimes gives a great deal of trouble ; and farther, if we rashly endeavour to extract, we irritate the uterus, and are apt to excite inflammation, or a train of hysterical, and sometimes fatal symptoms. It is these two circumstances which make me cautious in advising manual assistance ; and, fortunately, the proportion of cases requiring it is not great in abortion at an early period.

When part of the ovum is left, or the whole of the secundines are retained, then we have another danger besides hemorrhage ; for, within a few days, putrefaction comes on, and much irritation is given to the system, until the foetid substance be expelled. Sometimes, if gestation have not been far advanced, or the piece which is left is not very large, it continues to come away in small bits for many months ; and during the whole time, the woman is languid, hysterical, and subject to irregularities of the menstrua, very often to obstruction ; but more frequently the symptoms are very acute. We have loss of appetite, prostration of strength, tumid or tender belly, frequent, small, and sharp pulse, hot and parched state of the skin of the hands and feet, nocturnal sweats, and various hysterical symptoms. The discharge from the vagina is abominably foetid, and hemorrhage sometimes occurs to a violent degree. The treatment of this will hereafter be pointed out.

From these observations we may see upon the one hand the impropriety of allowing the secundines to remain too long in the uterus ; and, on the other, the danger of making rash or unnecessary attempts to extract, by which we irritate the uterus, and tear the placenta, which is almost always productive of troublesome consequences. I now return to the consideration of the usual progress of abortion. The stomach very soon suffers, and becomes debilitated, producing a general languor and feebleness, with a disposition to faint, which seems, in abortion, to depend more upon this cause than directly upon loss of blood. Indeed, the hemorr-

hage produces both slighter and less permanent effects in abortion than at the full time, although less blood may have been lost in the latter than in the former case, for the vessels are smaller, and the discharge is not so sudden. There is still another cause for this; namely, that the action of the uterus is less in the early than in the late months. Now, we know that the effect of hemorrhage from any organ is, *ceteris paribus*, in proportion to its degree of action. Hence the discharge is less dangerous than at the full time, and still less in menorrhagia than in abortion.

The effect of abortion on the stomach seems to be in proportion to the period at which it takes place, being greater when it occurs before the fourth month than after it. The effect, though distressing, and often productive of alarm, is nevertheless beneficial, lessening the action of the vessels in the same way with digitalis, the use of which is improper when this condition is present. The strength of the pulse is much abated; sometimes it becomes slower; but in general it remains much as formerly in point of frequency; we are therefore not to be too anxious in removing this condition, which restrains hemorrhage; yet as it may go beyond due bounds, and produce dangerous syncope, we must check it in time. We must likewise be very attentive to the state of the discharge when this affection is considerable, for if, notwithstanding this, the hemorrhage should continue, it will produce greater and more immediately hurtful effects than if this were absent.

The best method of abating this sinking and feebleness, is to keep the body perfectly at rest, and the head low. If necessary, we give small quantities of stomachic cordials, such as a little tincture of cinnamon, or a few drops of ether in a glass of aerated water; or we may give a little peppermint water, with fifteen drops of tincture of opium. In urgent cases, Madeira wine or undiluted brandy may be given; but these are not to be frequently repeated, and are very rarely necessary. Large doses of opium are also useful.

Sometimes, instead of a feeling of sinking and faintness, the fibres of the stomach are thrown into a spasmodic con-



traction, producing sudden and violent pain. This is a most alarming symptom, and may kill the patient very unexpectedly. It is to be instantly attacked by a mixture of sulphuric ether and tincture of opium, in a full dose, whilst a sinapism is applied to the epigastric region; but if, when this pain occurs, there be symptoms of approaching convulsions, then bleeding should precede the anodyne, and no ether should be given.

Spasms about the intestines are more frequent, and much less dangerous. They are very readily relieved by thirty drops of tincture of opium, in a desert-spoonful of aromatic tincture, or forty drops of the tincture of hyocyamus in two tea-spoonfuls of the compound tincture of lavender.

These disagreeable symptoms which I have described, fortunately do not often attend abortion; but the process goes on safely, and without disturbance. In this case, after it is over, we only find it necessary to confine the person to bed for a few days, as getting up too soon is apt to produce debilitating discharge. We must also, by proper treatment, remove any morbid symptoms which may be present, but which, depending on the peculiarities of individuals, or their previous state of health, cannot here be specified. When the patient continues weakly, the use of the cold bath, and sometimes of the bark, will be of much service in restoring the strength; and, in future pregnancies, great care must be taken that abortion may not happen again at the same period.

#### SECTION THIRTY-FIFTH.

Of all the incidents to which a pregnant woman is exposed, none is more alarming or troublesome than uterine hemorrhage, when it occurs in the advanced stages of gestation, or after the delivery of the child. This, from its extent and impetuosity, has aptly been called a flooding; and, from the frequency of its occurrence, it must be extremely interesting to every practitioner.

The ovum is connected to the uterus by means of a vast multitude of delicate vessels, which pass almost at every point from the one to the other. These vessels are large where the

placenta is attached ; smaller where they pass into the decidua.

As the ovum corresponds exactly to the inner surface of the uterus, and is in close and intimate contact with it, we find, that as long as this union subsists, the vessels, notwithstanding their delicacy, are enabled to transmit blood without effusion. But whenever a separation of the one from the other takes place, then these vessels are either directly torn ; or, even supposing them to extend a little, they must be ruptured by their own action, or by the force of the blood which they receive and circulate. When this happens, an extravasation or discharge must be the consequence, which will be greater or smaller in proportion to the number and magnitude of the vessels which have given way, and the strength of the action, which exists in the sanguiferous system.

The membranes are never so full of water as to be put upon the stretch, and therefore they cannot forcibly distend the womb; and make pressure on its inner surface. The womb again, during gestation, does not embrace the membranes tightly, so as to compress them. Hence it is evident, that when rupture first takes place, no resistance can, by the action of the one upon the other, be afforded to the flow of the blood. The consequence of uterine hemorrhage, when considerable, is, that the force of the circulation is diminished ; faintness, or absolute syncope being induced. The blood in this state flows more feebly ; coagulation is allowed to take place, and the paroxysm is for the present ended. This coagulation, in slight cases, may take place even without the intervention of faintness. Re-union, however, when the separation is extensive, and the coagulum considerable, cannot be expected to take place ; and therefore, when the clot loosens, a return of the hemorrhage is in general to be looked for.

One or more copious discharges of blood must injure the functions of the uterus, and ultimately destroy altogether the action of gestation. This tends to excite the muscular action of the uterine fibres ; and by their contraction two effects will be produced. The uterine vessels will be diminished in their diameter or capacity, and the whole surface of the

womb pressing more strongly upon the ovum, a greater resistance will be given to the flow of the blood.

Thus it appears, that nature attempts to save the patient in two ways. First, by the induction of a state of faintness, or sometimes of complete syncope, which tends to check the present attack. Secondly, when the hemorrhage is so great or obstinate as to prevent any possibility of the woman going safely to the full time, such effects are produced as tend to establish muscular contraction, and accelerate expulsion. This double process ought, in all our reasonings, to be held in view.

Uterine contraction is of two kinds, which may be called permanent and temporary. The permanent is that continued action of the individual fibres by which the uterus is rendered tense, so that it feels hard if the hand be introduced into its cavity. The temporary is that greater contraction which is excited at intervals for the expulsion of the fœtus, producing what are called the pains of labour.

In those cases where nature effects a cure by expulsion, or the production of labour, it is chiefly to the permanent or tonic contraction that we are indebted for the stoppage of hemorrhage; because this contraction lessens the size of the vessels, and keeps up a firm pressure of the uterine surface upon the ovum, until the pains have accomplished the expulsion or delivery of the child. The pains alone could not do this good; for coming only at intervals, their effect would be fugacious. On the other hand, the permanent contraction would not be adequate to the purpose, without the pains, for these temporary paroxysms excite this action to a stronger degree, and, by ultimately forcing down the child, accomplish delivery before the powers of the uterus be worn out.

Such are the steps by which the patient is naturally saved. But we are not to expect that these shall, in every instance, or in a majority of instances, take place at the proper time, or in the due degree. The debility and syncope may go too far; or the clots may not form in proper time, or may come away too soon, or too easily. The action of gestation may continue, notwithstanding the violence of the hemorrhage, thus preventing the accession of muscular con-



traction; or before this contraction be established and the child expelled, the discharge may have been so great and constant as to render the efforts of the womb weak and inefficient, and by still continuing, may destroy them altogether.

These circumstances being considered, it will be evident, that although when the injury is small, and the discharge trifling, nature may permanently check it; or, in more serious cases, may preserve the woman by the expulsion of the child; yet we cannot, with prudence, place our whole reliance on her unassisted operations.

There is also another circumstance relating to a particular species of flooding, which renders the accomplishment of a natural cure or escape still more doubtful. This is, that the placenta is sometimes attached to the os uteri, which necessarily must produce a hemorrhage whenever the cervix comes to be fully developed, and the mouth to open.

The vessels going to the placenta are much larger than those which enter the decidua; and therefore, if part of the placenta be detached, the quantity and velocity of the discharge must be greater, and the effects more to be dreaded, than when a part of the decidua alone is separated. If the placenta be fixed near the cervix uteri, and a part of it be detached, then the blood which is effused will separate the membranes down to the os uteri, and a profuse hemorrhage will appear. But sometimes, if it be fixed to the fundus uteri, the blood may be confined, especially if the separation have been trifling, and a coagulum will be formed exterior to the membranes, the lower part of which will still adhere to the uterus; or if the central portion of the placenta have been detached, a collection of blood may be formed behind it, but may not extend beyond its circular margin. But if the placenta be placed over the os uteri, then the case is different, profuse discharge will take place, sinking the whole system, and very much enfeebling the uterus itself, so that when uterine contraction does come on, it will be weak, and incapable of speedily effecting expulsion; even although the contraction should be brisk and powerful, it cannot, owing to the structure of the placenta, do the same good as in o-

ther cases of flooding; and therefore, in every instance, much blood will be lost, and in many, in very many, the patient, if we trust to this contraction alone, will perish. Contraction can only be expected in this case to do good, when it is powerful, and the pains come on so briskly as speedily to empty the uterus, at the same time that coagula shut the mouths of the placental vessels at the unsupported part.

It has been a common opinion, that flooding proceeded always from the detachment of part of the placenta; but this point is not established\*. In several cases of uterine hemorrhage, the placenta will be found attached to the fundus uteri; and we cannot suppose that in all of these, the whole extent of the membranes, from the placenta to the os uteri, has been separated: yet this must happen before the discharge can in these circumstances appear. We can often account for the hemorrhage, by supposing a portion of the decidua to be detached; and we know that the vessels about the cervix are sufficiently able to throw out a considerable quantity of blood, if their mouths be open. But in most cases of profuse hemorrhage, we shall find, that the placenta is attached near the os uteri, and more or less of it separated.

It is possible for blood to be effused in consequence of detachment of part of the ovum, and yet it may not be discharged by the os uteri†. This detachment may be produced by fatigue, falls, blows, &c. and the effusion is accompanied with dull internal pain at the spot where it takes place. This pain is something like colic, or like pain attending the approach of the menses. The part of the womb where the extravasation takes place, swells gradually, and the uterus in a short time feels larger. If the quantity be

\* Long ago, Andrea Pasta questioned the opinion, that flooding was always produced by separation of the placenta. Vide *Discorso del flusso di sangue*, &c. We are not, however, to suppose, that hemorrhage does not proceed from detachment of the placenta in any instance when it is placed high up, but only that it is a rare occurrence. When the stream is rapid and profuse, we have every reason to suppose that part of the placenta is separated; but if we have occasion to deliver, it will generally be found, that it is placed close by the cervix uteri, or at least not very far from it.

† Vide *Albinus Acad. Annot. lib. 1. p. 56. Recueil Periodique, tom. ii. p. 15. and tom. iii. p. 1.*

considerable, the size increases, the uterus is firmer and tenser, as well as larger, the strength diminishes, and even faintings may come on. In course of time, weak slow pains are felt, but if the injury be great, these decline as the weakness increases. They may or may not be attended with the discharge of coagula from the os uteri. In such a case, it is evident, that nothing but delivery can save the mother. But if no bad effect is produced, and the separation is not extensive, the accident may not be discerned or suspected, at least till after the child is born, when often a great quantity of blood is evacuated without affecting the pulse or strength, which it would do, did it come recently from the vessels of the uterus.

Let us next consider the causes giving rise to hemorrhage in various degrees; and the first which I shall mention is external violence, producing a separation of part of the ovum. As the ovum and uterus correspond exactly to each other, and are, in the advanced stages of gestation, composed of pretty pliable materials, falls or blows will not produce laceration so frequently as might be supposed. In a majority of instances the effect is produced chiefly by the operation on the vessels, their action being violently and suddenly excited, and rupture of their coats thus produced. When the ovum is mechanically detached, the injury must have been considerable, and in general the foetus is destroyed.

Fatigue, or much exertion, may injure the action of the uterus, and give rise to premature expulsion, which in this case is generally attended with considerable discharge. Such exertions are likewise apt, by their effect on the circulation, to operate on the vessels passing to the ovum, and produce in them a greater degree of activity than they are capable of sustaining without rupture. It is, therefore, very properly laid down as a rule of practice, to forbid pregnant women to undergo much fatigue, or exert any great muscular action; and wherever this rule has been departed from, especially by a patient of an irritable or of a plethoric habit, it behoves the practitioner to attend carefully to the first appearances of injury, or to the first symptoms of decay in the uterine action. Rest, and an opiate will upon general prin-



eiples be indicated, and when the circulation is affected, or we apprehend increased action about the uterine vessels, venesection must be premised, and the patient kept cool and tranquil.

Violent straining at stool, or strong exertions of the abdominal muscles, made in lifting heavy bodies, or in stretching to a height, or frequent and continued stooping, may all, by compressing the womb, cause separation. For the greatest effect will be produced where the resistance is least, or the support smallest, which is at the under part of the uterus, and there rupture will be apt to take place.

A preternatural degree of action in the vessels going to the placenta or decidua, must be dangerous, and likely to produce rupture and extravasation. This may either be connected with a general state of the vascular system, marked by plethora, or by arterial irritation; or it may be more immediately dependent on the state of the uterus itself.

When the woman is plethoric, or when the action of the vascular system is increased, it is natural to suppose, that the effect will be greatest on those parts of the womb which are in the highest state of activity. These are chiefly two; the part to which the placenta is attached, for there the vessels are large and numerous; and the cervix and os uteri, because there the greatest changes are going forward. At one or other of these two places, rupture is most likely to take place, and it will happen still more readily if the placenta be attached at or near to the cervix. It may be excited either by too much blood circulating permanently in the system, or by a temporary increase of the strength and velocity of the circulation produced by passion, agitation, stimulants, &c. A plethoric state is a frequent cause of hemorrhage in the young, the vigorous, and the active; the decidua is separated, and a considerable quantity of blood flows; perhaps the placenta is detached, and the hemorrhage is more alarming. In some cases the rupture is preceded by spitting of blood, or bleeding at the nose, and in these cases the lancet may be of much service.

We sometimes find that extravasation is produced by an

increased action of the uterine vessels themselves existing as a local disease. In this case, the patient for some time before the attack, feels a weight and uneasy sensation about the hypogastric region, with slight darting pains about the belly or back. These precursors have generally been ascribed to a different cause; namely, rigidity of the ligaments of the womb, or of the fibres of the uterus itself.

Spasmodic action about the os uteri, must produce a separation of the connecting vessels. The causes giving rise to this in the advanced period of gestation, are not always obvious, neither can we readily determine the precise cases in which this action excites flooding. We should expect that the discharge ought always to be preceded by pain, but we know that motion may take place in some instances about the os uteri without much sensation; and, on the other hand, many cases of flooding, not dependent on motion of the uterine fibres, are attended with uneasiness or irregular pain about the abdomen. This spasmodic action is not unfrequently produced by hanging pregnant animals.

Whatever stops prematurely the action of gestation, may give rise to a greater or less degree of hemorrhage. For in this case, the development of the cervix takes place quickly, and the ovum must be separated. The quantity of the discharge\* will depend upon the state of the circulation—the magnitude of the vessels which are torn—the contraction of the uterus—and the care which is taken of the patient. Hence it follows as a rule in every premature labour, more especially in its first stage, that we prevent all exertion, refrain from the use of stimulants, and confine the patient to a recumbent posture.

It sometimes happens, that effective contraction does not take place speedily after the action of gestation ceases, but a discharge appears. This may stop by the induction of syncope, or the formation of clots. The blood which is re-

\* In those cases where the contraction becomes universal and effective, we have little discharge, and the patient is merely said to have a premature labour; but if the contraction be partial, and do not soon become effective, then we have considerable discharge, and the patient is said to have a flooding.

tained about the cervix and os uteri putrefying, produces a very offensive smell. Milk is secreted as if delivery had taken place, and sometimes fever is excited. In this state the patient may remain for some days, when the hemorrhage is renewed, and the patient may be lost if we do not interfere.

Some undue state of action about the os uteri, removing, or ceasing to form that jelly which naturally ought to be secreted there, is another cause.

This is generally productive of a discharge of watery fluid, tinged with blood; and if the patient be not careful, pure blood may be thrown out in considerable quantity. It may even happen, that the hemorrhage, under certain circumstances, may prove fatal; and yet, upon dissection, no separation of the ovum be discovered, the discharge taking place from the vessels about the os uteri itself\*.

In some instances, where a portion of the placenta has been detached, I have observed, that near the separated part, the structure of the placenta was morbid, being hard and gristly. In these cases, I could not detect any other cause of separation, and suppose that by the accidental pressure of the child upon the indurated part, the uterus may have been irritated.

The insertion of the placenta over the os uteri†, may give rise to flooding in different ways.

The uterus and placenta may remain in contact until the term of natural labour, the one adapting itself to the other; but whenever the os uteri begins to dilate, separation and consequent hemorrhage must take place. It is rare, however, for the accident to be postponed so long. In general, at an earlier period, in the eighth, or by the middle of

\* Vide a case in point, by M. Heinigke, in the first volume of Brewer's *Biblioth. Germ.*

† So far as I have observed, uterine hemorrhage, when profuse, is produced most frequently by this cause; at least two-thirds of those cases requiring delivery, proceed, I think, from the presentation of the placenta; and in the majority of the remaining third, it will be found attached near to the cervix. Most of those hemorrhages, which are cured without delivery, proceed from the detachment of the decidua alone, or of a very small portion of the placenta, which has been separated under circumstances favourable for firm coagulation.



the ninth month, we find that either the uterus and placenta no longer grow equally, in consequence of which, the fibres about the os uteri are irritated to act; or so much blood as must necessarily, in this situation, circulate about the cervix uteri, interferes with its regular actions, and induces premature contraction of its fibres, with a consequent separation of the connecting vessels.

In order to ascertain whether the hemorrhage proceed from this cause, we ought, in every case to which we are called, carefully to examine our patient. The introduction of the finger is sometimes sufficient for this purpose, but frequently it may be necessary to carry the whole hand into the vagina.

If the placenta present, we shall feel the lower part of the uterus thicker than usual, and the child cannot be so distinctly perceived to rest upon it. This is ascertained by pressing with the finger on the fore part of the cervix, betwixt the os uteri and bladder, and also a little to either side\*.

If the os uteri be a little open, then by insinuating the finger, and carrying it through the small clots, we may readily ascertain whether the placenta or membranes present, by attending to the difference which exists betwixt them. But in this examination, we must recollect, that only a small portion of the edge of the placenta may present, and this may not readily be felt at first.

To conclude this part of the subject, I remark in general, that hemorrhage from the uterus is not merely arterial, but also venous, and the orifices of these latter vessels are extremely large. Almost immediately after conception, the veins enlarge and dilate, contributing greatly to give to the uterus the doughy feel which it possesses. In the end of gestation, the sinuses are of immense size, and their extremities so large, that in many places they will admit the point of

\* When a large coagulum occupies the lower part of the uterus, we may be deceived if we trust to external feeling alone, without introducing the finger within the os uteri. If the uterus have its usual feel, and the child be felt distinctly through it, then we are sure that, however near the placenta may be to the os uteri, it is not fixed exactly over it.

the finger. Now, as all the veins communicate more freely than the arteries, and as they have in the uterus no valves, we can easily conceive the rapidity with which discharge will take place, and the necessity of encouraging coagulation, which checks venous still more readily than arterial hemorrhage.

In whatever way flooding is produced, it has a tendency to injure or disturb gestation, and to excite expulsion; but these effects may be very slowly accomplished, and in a great many instances may not take place in time to save the patient or her child. Having already noticed those changes produced on the womb itself by hemorrhage, and the danger of trusting to them for the recovery of the patient, I will not recapitulate, but proceed very shortly to mention the effects produced on the system at large.

During the continuance of the hemorrhage, or by the repetition of the paroxysms, if this be allowed to take place, certain alterations highly important are taking place. There is much less blood circulating than formerly; and this blood, when the hemorrhage has been frequently renewed, is less stimulating in its properties, and less capable of affording energy to the brain and nerves. The consequence of this is, that all the actions of the system must be performed more languidly, and with less strength. The body is much more irritable than formerly, and slight impressions produce greater effects. This gives rise to many hysterical, and sometimes even to convulsive affections. The stomach cannot so readily digest the food—the intestines become more sluggish—the heart beats more feebly—the arteries act with little force—the muscular fibre contracts weakly—the whole system descends in the scale of action, and must, if the expression be allowable, move in an inferior sphere. In this state, very slight additional injury will sink the system irreparably—very trifling causes will unhinge its actions, and render them irregular. If the debility be carried to a degree farther, no care can recruit the system—no means can renew the vigor of the uterus. We may stop the hemorrhage, but recovery will not take place. We may deliver the child, but the womb will not contract. If when the system

is debilitated by hemorrhage, some irritation be conjoined, then the vascular action becomes more or less irregular, and an approximation is made to a state of fever. The pulse is feeble, but sharp; the skin rather warm; and the tongue more or less parched. This state is dangerous, both as it exhausts still more a system already very feeble, and also as it tends to renew the hemorrhage. It will often be found to depend upon slight uterine irritation, upon accumulation in the bowels, upon pulmonic affections, upon muscular pain, or upon the injudicious application of stimuli.

Such organs as have been previously disposed to disease, or have been directly or indirectly injured during the continuance of protracted flooding, may come to excite irritation, and give considerable trouble.

An acute attack of hemorrhage generally leaves the patient in a state of simple weakness; but if the discharge be allowed to be frequently conjoined, and the case thus protracted, some irritation often comes to be renewed, which adds to the danger, and excites, if the patient be not delivered, more speedy returns.

A woman seldom suffers much in a first attack of hemorrhage. If she be stout and plethoric, she may lose a great quantity of blood and yet to appearance not be greatly injured. The hemorrhage may come on in every different situation; in bed she may awake suddenly from a dream, and feel herself swimming in blood; or it may attack her when walking; or may be preceded by a desire to make water, and she is surprized to find the chamber-pot half filled with blood. She recovers from her consternation; perhaps in spite of every injunction, she walks about as usual, and finds no bad effect from motion; the feeling of heaviness which may have preceded the accident is gone, she is lighter and better than she was before it, and hopes all is well; but in a few days the hemorrhage is repeated, and again stops; at last, after one or two attacks, for the time is uncertain, the os uteri becomes soft, and opens a little, perhaps without pain, or she feels dull slight pains, which, however, give her very little uneasiness. This state may take place early, and



without dangerous debility ; it may take place in the second or third attack ; or possibly the hemorrhage may never have entirely ceased, but continued for a day or two like a flow of the menses, and then been suddenly increased, or may flow in a torrent. But although this state may take place without alarming debility, it may also, and that very suddenly, be attended with the utmost danger, or may be accompanied with so much hemorrhage as to prove absolutely fatal. The patient is found without a drop of blood in her face, the extremities cold, the pulse almost gone, the stomach unable to retain drink. She is in the last stage of weakness, but it is not the weakness produced by fever or disease, for we find her voice good and generally the intellect clear. The hemorrhage has stopped, and a young man would suppose it still possible for her to recover. But although not a drop of blood is afterwards lost, the debility increases, the pulse is quite gone, she breathes with difficulty, and gives long sighs, wavers in her speech, and in a short time expires.

We may lay it down as a general observation, that few cases of profuse hemorrhage, occurring in an advanced stage of gestation, can be cured without delivery or the expulsion of the child. For when the discharge is copious or obstinate, the placenta is generally separated, sometimes to a very considerable extent, and a re-union, without which the woman can never be secure against another attack, can rarely be expected. If the placenta present, the hemorrhage, although suspended, will yet to a certainty return, and few will survive if the child be not delivered.

But in those cases where only a portion of the decidua, or a little bit of the margin of the placenta \* has been detached, and the communicating vessels opened, either by a state of over-action in the vascular system, or by too much blood in the vessels, or by some mechanical exertion, if proper care be taken, the hemorrhage may be completely and permanently checked ; or if it should return, it may be kept so much under, or may consist so much of watery discharge from the

\* In this case, after labour is over, we may discover the separated portion by the difference of colour ; it is generally browner and softer than the rest.

glands about the os uteri, as neither to interfere with gestation, nor injure the constitution; yet it is to be recollected, that even these cases of flooding may sometimes proceed to a dangerous degree, requiring very active and decided means to be used; and in no case can the patient be considered as safe, unless the utmost care and attention be paid to her conduct.

It would thus appear, that some hemorrhagies almost inevitably end either in the delivery of the child, or the death of the parent; whilst others may be checked or moderated without an operation. A precise diagnostic line, liable to no exceptions, cannot be drawn betwixt these cases; and therefore, whilst we believe that rapid and profuse hemorrhagies, which indicate the rupture of large vessels, can seldom be permanently checked, we still, provided the placenta do not present, are not altogether without hopes of that termination, which is more desirable for the mother, and safer for the child, than premature delivery. In slighter cases, our hope is joined with some degree of confidence.

A second attack, especially if it follow soon after the first, and from a slight cause, or without any apparent cause, greatly diminishes the chance of carrying the woman to a happy conclusion without manual interference.

In forming our opinion respecting the immediate danger of the patient, we must consider her habit of body, and the previous state of her constitution. We must attend to the state of the pulse, connecting that in our mind with the quantity and rapidity of the discharge. A feeble pulse, with a hemorrhage, moderate in regard to quantity and velocity, will, if the patient have been previously in good health, generally be found to depend on some cause, the continuance of which is only temporary. But when the weakness of the pulse proceeds from profuse or repeated hemorrhage, then although it may sometimes be rendered still more feeble by oppression, or feeling of sinking at the stomach; yet, when this is relieved, it does not become firm. It is easily compressed, and easily affected by motion; or, sometimes, even by raising the head.

If the paroxysm is to prove fatal, the debility increases—the pulse flutters—the whole body becomes cold and clammy—the breathing is performed with a sigh—and syncope closes the scene.

If irritation be conjoined with hemorrhage, then the pulse is sharper, and, although death be near, it is felt more distinctly than when irritation is absent.

The termination in this case is often more sudden than a person, unacquainted with the effect of pain or irritation on the pulse, would suppose. For when the pulsation is distinct, and even apparently somewhat firm, a slight increase of the discharge, or sometimes an exertion without discharge, speedily stops it, the heat departs, and the patient never gets the better of the attack.

We must likewise remember, that a discharge, which takes place gradually, can be better sustained than a smaller quantity, which flows more rapidly. For the vessels in the former case come to be accustomed to the change, and are able more easily to accommodate themselves to the decreased quantity. But when blood is lost rapidly, then very speedy and universal contraction is required in the vascular system, in order that it may adjust itself to its contents, and this is always a debilitating process. The difference too betwixt the former and the present condition of the body, is rapidly produced, and has the same bad effect as if we were instantly to put a free-liver upon a very low and abstemious diet.

In all cases of flooding, we find, that during the paroxysm, the pulse flags, and the person becomes faint. Complete syncope may even take place, but this in many cases is more dependent on sickness or oppression at the stomach, than on direct loss of blood. In delicate and irritable habits, the number of fainting fits may be great, but unless the patient be much exhausted, we generally find that the pulse returns, and the strength recruits. The prognosis here must depend greatly on the quantity and velocity of the discharge; for it may happen, that the first attack of hemorrhage may produce a syncope, from which the patient is never to recover.

When we are called to a patient recently attacked with



flooding, our most obvious duty is immediately to restrain the violence of the discharge; after which we can take such measures as the nature of the case may demand, either for preserving gestation, or for hastening the expulsion of the child.

A state of absolute rest, in a horizontal posture, is to be enforced with great perseverance, as the first rule of practice. By rest alone, without any other assistance, some hemorrhagies may be cured; but, without it, no woman can be safe. Even after the immediate alarm of the attack is over, the woman must still recollect her danger. She should be confined to bed, upon a firm mattress, for several days, and ought not to leave her apartment for a much longer period.

In general, the patient has gone to bed before we are called; and, perhaps, by the time that we arrive, the bleeding has in a great measure ceased. The partial unloading of the vessels, produced by the rupture, the induction of a state approaching to syncope in consequence of the discharge, the fear of the patient, and a horizontal posture, may all have conspired to stop the hemorrhage.

The immediate alarm from the flooding having subsided, the patient often expresses herself as more apprehensive of a premature labour, than of the hemorrhage, which she considers as over. If the attack have been accompanied with slight abdominal pain, her fears are confirmed. But we are not to enter into these views of the case; we are to consider the discharge as the prominent symptom, as the chief source of danger. We are to look upon the present abatement as an uncertain calm; and whatever advice we may give, whatever remedies we may employ, we are not to leave our patient until we have strongly enforced on her attendants the danger of negligence, and the necessity of giving early intimation should the hemorrhage be renewed. There is no disease to which the practitioner can be called, in which he has greater responsibility than in uterine hemorrhage. The most prompt and decided means must be used; the most patient attention must be bestowed; and, whenever he undertakes the management of a case of this kind, whatever be the

situation of the patient, he must watch her with constancy, and forget all consideration of gain and of trouble. His own reputation, his peace of mind, the life of his patient, and that of her child, are all at stake. I am doing the student the most essential service, when I earnestly press upon his attention these considerations. And when I intreat, implore him to weigh well the proper practice to be pursued, the necessary care to be bestowed, I am pleading for the existence of his patient, and for his own honour and happiness. Procrastination, irresolution, or timidity, have hurried innumerable victims to the grave; whilst the rash precipitation of unfeeling men has only been less fatal, because negligence is more common than activity.

I shall endeavour to point out the proper treatment in the commencement of uterine hemorrhage, and the best method of terminating the case when the patient cannot be conducted with safety to the full time. After the patient is laid in bed, it is next to be considered how the hemorrhage is to be directly restrained, and whether we may be able to prevent a return. It is at all times proper to ascertain exactly the situation of the patient by examination, as we thus learn the state of the cervix and os uteri, and whether there be any tendency to labour; whether the discharge be stopped by a coagulum in the mouths of the vessels \*, or by a large clot in the upper part of the vagina; whether the placenta be attached to os uteri, or whether the membranes present. We likewise endeavour to ascertain the quantity of blood which has been lost—the rapidity with which it flowed—the effect which it has produced upon the mother or child—and the cause which appeared to excite the hemorrhage.

The first remedy which, upon a general principle, offers itself to our attention, is blood-letting. In those cases, where the attack has been produced by over-action of the vessels, or a plethoric condition; or where it seems to be kept up by

\* We may conjecture that this is the case, if we find no clot in the vagina, plugging the os uteri. We are not warranted to thrust the finger forcibly within the os uteri, in this examination; or to rub away the small coagula which may be formed within it, and which may be restraining the hemorrhage.

these causes, this remedy employed early, and followed by other means, may be effectual not only in checking the present paroxysm, but also in preventing a return. By the timely and decided use of the lancet, much distress may be avoided, and both the mother and the child may be saved from danger. But we are not to apply the remedy for one state to every condition; we must have regard to the cause, and consider how far the hemorrhage is kept up by plenitude or morbid activity of the vessels. In those cases where the attack is not excited by, or connected with plethora, or undue action in the vascular system, venesection is not indicated. We have in these cases, which are, I believe, by far the most numerous, other means of safely, and powerfully moderating vascular action, without the detraction of blood, which in this disease it ought to be a leading principle to save as much as possible. Whatever lessens materially or suddenly the quantity of blood, must directly enfeeble, and call for a new supply, otherwise the system suffers for a long time.

We shall find, that except under those particular circumstances which I have specified, and where we have ground to believe, that the rupture of vessels has been dependent on their plenitude or over-action, the circulation may be speedily moderated by other means, and especially by the application of cold. This is to be made not only by applying cloths dipped in cold water to the back and vulva, but also by sponging over the legs, arms, and even the trunk, with any cold fluid; covering the patient only very lightly with clothes, and promoting a free circulation of cold air, until the effect upon the vessels be produced. After this we shall find no advantage, but rather harm from the further application of cold. All that is now necessary, is strictly and constantly to watch against the application of heat, that is, raising the temperature above the natural standard.

The extent to which this cooling plan is to be carried, must depend upon circumstances. In a first attack, it is in general to be used in all its vigour; but where the discharge, either towards the end of this attack, or in a subsequent paroxysm, has gone so far as to reduce the heat much below the natural standard, the vigorous application of cold might



sink the system too much. In some urgent cases it may even be necessary to depart from our general rule, and apply warm cloths to the hands, feet, and stomach. This is the case where the discharge has been excessive, and been suffered to continue profuse or for a long time, and where we are afraid that the system is sinking fast, and the powers of life giving way. There are cases in which some nicety is required in determining this point, and in these circumstances we must never leave our patient, but must watch the effects of our practice. This is a general rule in all hemorrhagies, whatever their cause may have been, or from whatever vessel the blood may come. A cold skin and a feeble pulse never can require the positive and vigorous application of cold; but, on the other hand, they do not indicate the application of heat, unless they be increasing, and the strength declining. Then we cautiously use heat to preserve what remains, not rashly and speedily to increase action beyond the present state of power.

When an artery is divided, it is now the practice to trust for a cure of the hemorrhage to compression, applied by a ligature. We cannot, however, apply pressure directly and mechanically to the uterine vessels, but we can promote coagulation, which has the same immediate effect. Rest and cold are favourable to this process, but ought only in slight cases to be trusted to alone. In this country it has been the practice to depend very much upon the application to the back or vulva, of cloths dipped in a cold fluid, generally water, or vinegar and water; but these are not always effectual, and sometimes, from the state of the patient, are not admissible.

Plugging the vagina with a soft handkerchief,\* answers every purpose which can be expected from them; and whenever a discharge takes place to such a degree as to be called a flooding, or lasts beyond a very short time, this ought to

\* The insertion of a small piece of ice in the first fold of the napkin, is attended with great advantage, and has often a very powerful effect. Dr Hoffman employed the introduction of lint, dipped in solution of vitriol; but this was rather as an astringent than a plug; and he does not propose it as a general practice. He considers, that he was obliged to have recourse ad anceps et extremum auxilium.—Vide Opera Omnia, t. iv. Leroux employed the plug more freely.—Vide Observations sur les Pertes, 1776.

be resorted to. The advantage is so great and speedy, that I am surprised that it ever should be neglected. I grant that some women may, from delicacy or other motives, be averse from it; but every consideration must yield to that of safety: and it should be impressed deeply on the mind of the patient, as well as of the practitioner, that blood is most precious, and not a drop should be spilled which can be preserved. Unless the flooding shall in the first attack be permanently checked, which, when the separated vessels are large or numerous, is rarely accomplished, we may expect one or more returns before expulsion can be accomplished. The more blood, then, that we allow to be lost at first, the less able will the patient be to support the course of the disease, and the more unfavourable will delivery, when it comes to be performed, prove to her and to the child. It is of consequence to shorten the paroxysm as much as possible; and, therefore, when circumstances will permit, we should make it a rule to have from the first a careful nurse, who may be instructed in our absence to use the napkin without delay, should the hemorrhage return.

But whilst I so highly commend, and so strongly urge the use of the plug, I do not wish to recommend it to the neglect of other means, or in every situation. In the early attacks of hemorrhage, when the os uteri is firm, and manual interference is improper, I know of no method more safe or more effectual for restraining the hemorrhage and preserving the patient. But when the hemorrhage has been profuse, or frequently repeated, and the circumstances of the patient demand more active practice, and point out the necessity of delivery, then the use of the plug cannot be proper. If trusted to, it may be attended with fatal and deceitful effects. We can indeed restrain the hemorrhage from appearing outwardly; but there have been instances, and these instances ought to be constantly remembered, where the blood has collected within the uterus, which, having lost all power, has become relaxed, and been slowly enlarged with coagula; the strength has decreased—the bowels become inflated—the belly swelled beyond its size in the ninth

month, although the patient may not have been near that period; and in these circumstances, whilst an inattentive practitioner has perhaps concluded that all was well with regard to the hemorrhage, the patient has expired, or only lived long enough to permit the child to be extracted. All practical writers warn us against internal flooding; nay, so far do some carry their apprehension, that they advise us to raise the head of the child, and observe whether blood or liquor amnii be discharged;\* an advice, however, to which I cannot subscribe, because in those cases where the membranes have given way, or been opened, the head cannot be thus moveable, nor these trials made, unless we have waited until a dangerous relaxation has taken place in the uterine fibres; and if, on the other hand, we have delivery in contemplation, it is our object to confine the liquor amnii as much as possible, until we turn the child.

Besides using these means, it will also, especially in a first attack, and where we have it not in contemplation to deliver the woman, be proper to exhibit an opiate, in order to allay irritation; and this is often attended with a very happy effect.

Such are the most effectual methods of speedily or immediately stopping the violence of the hemorrhage. The next points for consideration are, whether we can expect to carry the patient safely to the full time, and by what means we are to prevent a renewal of the discharge.

It may, I believe, be laid down as a general rule, that when a considerable portion of the decidua has in the seventh month, or later, been separated, the hemorrhage, although it may be checked, is apt to return. When a part of the placenta has been detached, and more especially if that organ be fixed over the os uteri, gestation cannot continue long; for either such injury is done to the uterus as produces expulsion and a natural cure, or the woman bleeds to death, or we must deliver, in order to prevent that dreadful termination.

\* Vide Dr Johnson's *System of Midwifery*, p. 157; and Dr Leak's *Diseases of Women*, vol. ii. p. 230.



If the discharge be in small quantity, and have not flowed with much rapidity—if it stop soon or easily—if no large clots are formed in the vagina—if the under part of the uterus has its usual feel, shewing that the placenta is not attached there, and that no large coagula are retained within the os uteri—if the child be still alive—if there be no indication of the accession of labour—and if the slight discharge which is still coming away be chiefly watery, we may in these circumstances conclude that the vessels which have given way are not very large, and have some reason to expect, that by care and prudent conduct, the full period of gestation may be accomplished. It is difficult to say, whether in this event the uterus forms new vessels to supply the place of those which have been torn, and whether re-union be effected by the incorporation of these with corresponding vessels from the chorion. In a case of abortion, we know that re-union takes place; but when, in the advanced period of pregnancy, the decidua has become very thin, soft, and almost gelatinous, it is not established that the circulation may be renewed. At all events, we know that the power of recovery or reparation is very limited, and can only be exerted when the injury is not extensive. The means for promoting re-union of the uterus and decidua, are the same with those which we employ for preventing a return of the hemorrhage; and these we advise, even when we have little hope of effecting re-union, and making the patient go to the full time, because it is our object to prevent as much as possible the loss of blood.

When the placenta is partly separated, all the facts of which we are in possession are against the opinion that re-union can take place. If the spot be very trifling, and the vessels not large, we may have no return of the bleeding; a small coagulum may permanently restrain it; but if the separation be greater, and the placenta attached low down, or over the os uteri, the patient cannot go to the full time, unless that be very near its completion. We judge of the case by the profusion and violence of the discharge; for all great hemorrhagies proceed from the separation of the pla-

centa; and by the feel of the lower part of the uterus,—by the quantity of clots, and the obstinacy of the discharge, which may perhaps require even actual syncope to stop the paroxysm; a circumstance indicating great danger.

The best way by which we can prevent a return, is to moderate the circulation, and keep down the actions of the system to a proper level with the power. The propriety of attending to this rule will appear, if we consider, among other circumstances, that when a patient has had an attack of flooding, a surprise, or any agitation which can give a temporary acceleration to the circulation, will often renew the discharge. The action of the arteries depends very much upon that of the heart; and the action of this organ again is dependant on the blood. When much blood is lost, the heart is feebly excited to contraction, and in some cases it beats with no more force than is barely sufficient to empty itself. This evidently lessens the risk of a renewal of the bleeding; and in several cases, as, for example, in hemoptysis, we, by suddenly detracting a quantity of blood, speedily excite this state of the heart. Whatever tends to rouse the action of the heart, tends to renew hemorrhage; and if the proposition be established, that the rapidity with which the strength and action of the vessels are diminished is much influenced by the rapidity with which a stimulus is withdrawn, the converse is also true, and we should find, were it practicable to restore the quantity of blood as quickly as it has been taken away, that the same effect would be produced on the action of the heart, as if a person had taken a liberal dose of wine. It has been the practice to give nourishing diet to restore the quantity of blood; but until the ruptured vessels be closed, or the tendency to hemorrhage stopped, this must be hurtful. It is our anxious wish to prevent the loss of blood; but it does not thence follow, that, when it is lost, we should wish rapidly to restore it. This is against every principle of sound pathology; but it is supported by the prejudices of those who do not reflect, or who are ignorant of the matter. When a person is reduced by flooding, even to a slight degree, taking much food into the

stomach gives considerable irritation ; and if much blood be made, vascular action must be increased. What is it which stops the flow of blood, or prevents for a time its repetition ? Is it not diminished force of the circulation which cannot overcome the resistance given by the coagula ? Does not motion displace these coagula, and renew the bleeding ? Does not wine increase for a time the force of the circulation, and again excite hemorrhage ? Is it not conformable to every just reasoning, and to the experience of ages, that full diet is dangerous when vessels are opened ? Do we not prohibit nourishing food and much speaking in hemorrhage from the lungs ? and can nourishing diet and motion be proper in hemorrhage from the uterus ? If it were possible to restore in one hour the blood which has been lost in a paroxysm of flooding, it is evident, that unless the local condition of the parts were altered, the flooding would at the end of that hour be renewed.

The diet should be light, mild, given in small quantity at a time, so as to produce little irritation\*, and much fluid, which would soon fill the vessels, should be avoided. We shall do more good by avoiding every thing which can stimulate and raise action†, than by replenishing the system rapidly, and throwing rich nutriment into the stomach.

It is, however, by no means my intention to say, that we must, during the whole remaining course of gestation, (provided that that go on, the attack having been permanently

\* Such as animal jellies, sago, toasted bread, hard biseuit, &c. These articles, given at proper intervals, are sufficient to support the system without raising the action to much.

† The system, with its power of action, may, for illustration, be compared to a man with his income. He who had formerly two hundred pounds per annum, but has now only one, must, in order to avoid bankruptcy, spend only one half of what he did before ; and if he do so, although he has been obliged to live lower, yet his accounts will be square at the end of the year.—The same applies to the system. When its power is reduced, the degree of its action must also be reduced ; and, by carefully proportioning the one to the other, we may often conduct a patient through a very great and continued degree of feebleness. At the same time, it must be observed, that as there is an income so small as not to be sufficient to procure the necessaries of life, so also may the vital energy be so much reduced as to be inadequate to the performance of those actions which are essential to our existence, and death is the result. But surely he who should attempt to prevent this by stimulating the system, would only hasten the fatal termination : Does not heat overpower and destroy those parts which have been frost-bit ?



cured) keep down the quantity of blood. I only mean that we are not rapidly to increase it. Even where the strength has been much impaired by the profusion of the discharge, or the previous state of the system, it is rather by giving food so as to prevent farther sinking, than by cramming the patient, that we promote recovery; and I beg it to be remembered, that although I talk of the management of those who are much reduced, yet I am not to be understood as in any degree encouraging the practice of delay, and allowing the patient to come into this situation of debility; but when we find her already in this state, it is not by pouring cordials and nutriment profusely into the stomach, that we are to save her; it is by preventing farther loss and farther weakness; it is by giving mild food, so as gradually to restore the quantity of blood and the strength; it is by avoiding the stimulating plan on the one hand, and the starving system on the other, that we are to carry her safely through the danger.

Some medicines possess a great power over the blood vessels, and enable us in hemorrhage to cure our patient with less expence of blood than we could otherwise do. The digitalis is of this class, and may often be given with much advantage in flooding, where the pulse indicates increased vascular action, and when we do not mean to proceed directly to delivery. But when the discharge has been trifling, and the pulse is slow, and perhaps feeble, the digitalis is unnecessary even from the first; and if, in the progress of the distase, the stomach have become affected, and the patient is sick, inclined to vomit, or faintish, or the pulse feeble and small, it is likewise improper.

In those cases which demand it, when the pulse is sharp, and throbbing, and frequent, it may be given either in the form of powder or of tincture; half a grain of the dried leaves may be given every two hours, until the pulse be affected, and afterwards at longer intervals, so as to keep the circulation moderate. The tincture may also be employed with the same advantage. Two drams may be added to a four-ounce mixture, and a table spoonful given every two hours, watching the effect, and diminishing the dose when necessary.

The addition of a little well-prepared hepatised ammonia sometimes makes the effect be more speedily produced, but not more than five drops should be added to each dose.

At the same time that we thus endeavour to diminish the action of the vascular system, we must also be careful to remove as far as we can every irritation. I have already said all that is necessary with regard to heat, motion, and diet. The intestinal canal must also be attended to, and accumulation within it should be carefully prevented by the regular exhibition of laxatives. A costive state is generally attended with a slow circulation in the veins belonging to the hepatic system, and of these the uterine sinuses form a part. If the arterial system be not proportionally checked, this sluggish motion is apt, by retarding the free transmission along the meseraic veins, to excite the hemorrhage again.

Uneasiness about the bladder or rectum, or even in more distant parts, should be immediately checked; for, in many cases, hemorrhage is renewed by these irritations. In those cases, or where the patient is troubled with cough, or affected with palpitation, or an hysterical state, much advantage may be derived from the exhibition of opiates. In many instances where an attack of flooding is brought on by some irritation affecting the lower part of the uterus in particular, or the system in general, or where the bowels are pained, and the pulse not full nor strong, rest, cool air, and an adequate dose of tincture of opium will terminate the paroxysm, and perhaps prevent a return. This is especially the case, if only a part of the decidua have been separated, and the discharge have not been profuse. When the vascular system is full, venesection is necessary before the anodyne be administered, and the digitalis may either succeed the opiate, or be omitted, according to the state of the pulse and of the stomach.

But although anodynes be in many instances, and especially in first attacks, of great benefit, yet they are not to be indiscriminately employed nor exhibited when the circumstances of the patient require delivery, unless the strength be much impaired; and then, a full dose is to be given as a cordial, previous to delivery.

It may happen that we have not been called early in a first attack, and that some urgent symptom has appeared. The most frequent of these, is a feeling of faintness or complete syncope. This feeling often arises rather from an affection of the stomach than from absolute loss of blood; and in this case it is less alarming than when it follows copious hemorrhage. In either case, however, we must not be too hasty in exhibiting cordials. When the faintishness depends chiefly upon sickness at the stomach, or feeling of failure, circumstances which may accompany even a small discharge, it will be sufficient to give a few drops of hartshorn in cold water, and sprinkle the face with cold water. When it is more dependant on absolute loss of blood, we may find it necessary to give small quantities of wine warmed with aromatics; but our cordials even in this case must not be given with a liberal hand, nor too frequently repeated\*. It is scarcely necessary for me to add, that we are also to take immediate steps by the use of the plug, &c. for restraining the discharge. This I may observe once for all.

Complete syncope is extremely alarming to the bye-standers; and, if there have been a great loss of blood, it is indeed a most dangerous symptom. It must at all times be relieved, for although faintness be a natural mean of checking hemorrhage, yet absolute and prolonged syncope is hazardous. But we are not to exhibit large doses of cordials for its removal. We must keep the patient at perfect rest, in a horizontal posture, with the head low, open the windows, sprinkle the face smartly with cold vinegar, apply volatile salts to the nostrils, and give some hartshorn, or a spoonful of warm wine internally.

Universal coldness is also a symptom which must not be allowed to go beyond a certain degree, and this degree must be greatly determined by the strength of the patient and the

\* As syncope and loss of blood have both the effect of relaxing the muscular fibre, as is well known to surgeons, it may be supposed that they should increase the flooding by diminishing the contraction of the uterus, if that have already taken place. But the contrary is the case, for by allowing coagula to form, syncope restrains hemorrhage, and therefore ought not to be too rapidly removed.



quantity and rapidity of the discharge. When the strength is not previously much reduced, a moderate degree of coldness is, if the hemorrhage threaten to continue, of service; but when there has been a great loss of blood, then universal coldness, with pale lips, sunk eyes, and an approaching deliquium, may too often be considered as a forerunner of death. When we judge it necessary to interfere, we should apply warm cloths to the hands and feet, a bladder half filled with tepid water to the stomach, and give some hot wine and water internally.

Vomiting is another symptom which sometimes appears. It proceeds very generally from the attendants having given more nourishment or fluid than the stomach could bear, or from a gush of blood taking place soon after the patient has had a drink. It in this case is commonly preceded by sickness and oppression, which are most distressing, and threaten syncope until relief is obtained by vomiting. Sometimes it is rather connected with an hysterical state, or with uterine irritation. If frequently repeated, it is a debilitating operation, and by displacing clots may renew hemorrhage; but sometimes it seems fortunately to excite the contraction of the uterus, and gives it a disposition to empty itself. For abating vomiting, we may apply a cloth dipped in laudanum, and camphorated spirits of wine, to the whole epigastric region; or give two grains of solid opium, or even more, if the weakness be great. Sometimes a little infusion of capsicum is of service. It should just be gently pungent. In flooding it is of importance to pay much attention to the state of the stomach, and prevent it from being loaded; on the other hand, we must not let it remain too empty, nor allow its action to sink. Small quantities of pleasant nourishment should be given frequently. We thus prevent it from losing its tone, without oppressing it, or filling the system too fast.

Hysterical affections often accompany protracted floodings, such as globus, pain in the head, feeling of suffocation, palpitation\*, retching, in which nothing but wind is got up,

\* The quantity of blood lost is sometimes so great as to do irreparable injury to the heart, and ever after to impede its action. One well marked instance of

&c. These are best relieved by some foetid or carminative substance conjoined with opium. The retching sometimes requires an anodyne clyster, or the application of a camphorated plaster\*, to the region of the stomach.

After having made these observations on the management of flooding, and the best means of moderating its violence, of preventing a return, and of relieving those dangerous symptoms which sometimes attend it; I next proceed to speak of the method of delivering the patient when that is necessary. I have separated the detail of the medical treatment of a paroxysm from the consideration of the manual assistance, which may be required; because, however intimately connected the different parts of our plan may be in actual practice, it is useful in a work of this kind, in order to avoid confusion, that I lay them down apart.

As some peculiarities of practice arise from the implantation of the placenta, over the os uteri, I shall confine my present remarks to those cases in which the membranes are found at the mouth of the womb, desiring it to be remembered, however, that this circumstance does not necessarily indicate that the hemorrhage does not proceed from separation of the placenta, which may be fixed very near the cervix, although it cannot be felt.

The operation of delivering the child is not difficult to describe or to perform. The hand, previously lubricated, is to be slowly and gently introduced completely into the vagina. The finger is to be introduced into the os uteri, and cautiously moved so as to dilate it; or if it has already dilated a little more, two fingers may be inserted, and very slow and gentle attempts made at short intervals to distend it; and the practitioner will do well to remember, that he will succeed best when he rather acts so as to stimulate the uterus, and make it dilate its mouth, than directly to distend it. On

this is related by Van Swieten, in his commentary on Aph. 1204, where, for twelve years the woman after a severe flooding, could not sit up in bed without violent palpitation and anxiety.

\* This may be made by melting a little adhesive plaster, and then adding to it a large proportion of camphor, previously made into a thick liniment by rubbing it with olive oil.

the part of the operator is demanded much tenderness, caution, firmness, and composure; on the part of the patient is to be desired patience and resolution. The operator is to keep in mind, that painful dilation is dangerous, it irritates and inflames the parts, and that the woman should complain rather of the uterine pains which are excited, than of the fingers of the practitioner. More or less time will be required fully to dilate the os uteri, according to the state in which the uterus was when the operation was begun. If the os uteri is soft and pliable, and has already by slight pains been in part distended, a quarter of an hour, or perhaps only a few minutes will often be sufficient for this purpose; but if it has scarcely been affected before by pains, and is pretty firm, though not unyielding, then half an hour may be required. I speak in general terms, for no rule can be given applicable to every case. Not unfrequently, although the patient have felt scarcely any pains, and certainly no regular pains; the os uteri will be found as large as a penny-piece, and its margin soft and thin. The os uteri being sufficiently dilated, the membranes are to be ruptured, the hand introduced, the child slowly turned and delivered, as in footling cases; endeavouring rather to have the child *expelled* by uterine contraction than *brought away* by the hand. Hasty extraction is dangerous, for the uterus will not contract after it. And, therefore, if when we are turning, we do not feel the uterus acting, we must move the hand a little, and not begin to deliver until we perceive that the womb is contracting. The delivery must be but slow until the breech is passing, then we must be careful that the cord be not too long compressed before the rest of the child be born. The child being removed, and the belly properly supported, and gently pressed on by an assistant, the hand should again be cautiously introduced into the womb, and the two knuckles placed on the surface of the placenta, so as to press it a little, and excite the uterus to separate it. The hand may also be gently moved in a little time, and the motion repeated at intervals, so as to excite the uterus to expel its contents; but upon no account are we to separate the placenta and extract it. This must be done



by the uterus; for we have no other sign that the contraction will be sufficient to save the woman from future hemorrhage. The whole process, from first to last, must be slow and deliberate, and we are never to lose sight of our object, which is to excite the expulsive power of the uterus. It is not merely to empty the uterus—it is not merely to deliver the child, that we introduce our hand: all this we may do, and leave the woman worse than if we had done nothing: The fibres must contract and press upon the vessels; and as nothing else can save the patient, it is essential that the practitioner have clear ideas of his object, and be convinced on what the security of the patient depends.

But to teach the method of delivery, and say nothing of the circumstances under which it is to be performed, would be a most dangerous error. I have in the beginning of this section, pointed out the effect of hemorrhage, both on the constitution and on the uterus; and I have stated, that the action of gestation is always impaired by a certain loss of blood, and a tendency to expulsion brought on. But before the uterine contraction can be fully excited, or become effective, the woman may perish, or the uterus be so enfeebled as to render expulsion impossible. Whilst then we look upon the one hand to the induction of contraction, we must not on the other delay too long. We must not witness many and repeated attacks of hemorrhage; sinking the strength; bleaching the lips and tongue, producing repeated fainting fits, and bringing life itself into immediate danger. Such delay is most inexcusable and dangerous; it may end in the sudden loss of mother and child; it may enfeeble the uterus, and render it unable afterwards to contract; or it may so ruin the constitution, as to bring the patient, after a long train of sufferings, to the grave.

Are we then uniformly to deliver upon the first attack of flooding, and forcibly open the os uteri? By no means; safety is not to be found either in rashness or procrastination.

The treatment which I have pointed out, will always secure the patient until the delivery can be safely accomplished. As long as the os uteri is firm and unyielding—as long

as there is no tendency to open, no attempt to establish contraction, it is perfectly safe to trust to the plug, rest, and cold. But I must particularly state to the reader, that the os uteri may dilate without regular pains; and in almost every instance it does, whether there be or be not pains, become dilatable. Did I not know the danger of establishing positive rules, I would say, that as long as the os uteri is firm, and has no disposition to open, the patient can be in little risk if we understand the use of the plug; we may even plug the os uteri itself, which will excite contraction. But if the patient be neglected, then I grant that long before a tendency to labour or contraction be introduced, she may perish. I am not, however, considering what may happen in the hands of a negligent practitioner; for, of this, there would be no end, but what ought to be the result of diligence and care.

It is evident, that when the uterus has a disposition to contract, and the os uteri to open, delivery must be much safer and easier than when it is still inert, and the os uteri hard.

We may with confidence trust to the plug, until these desirable effects be produced; and, in some instances, we shall find, that by the plug alone we may secure the patient: the contraction may become brisk, if we have prevented much loss of blood, and expulsion may naturally take place. Who would, in those circumstances, propose to turn the child, and deliver it? Who would not prefer the operation of nature to that of the accoucheur? To determine in any individual case whether this shall take place, or whether delivery must be resorted to, will require deliberation on the part of the practitioner. If he have used the plug early and effectually, and the pains have become brisk, he has good reason to expect natural expulsion; and the labour must be conducted on the general principles of midwifery. But if the uterus have been enfeebled by loss of blood—if the pains are indefinite,—if they have done little more than just open the os uteri, and have no disposition to increase; then he is not justified in expecting that expulsion shall be naturally and

safely accomplished, and he ought to deliver. When he dilates the os uteri, he excites the uterine action, and feels the membranes become tense. But he must not trust to this: he must finish what he has begun.

Thus it appears, that by the early and effective use of the plug, by filling the vagina with a soft napkin, or with tow, we may safely and readily restrain hemorrhage, until such changes have taken place on the os uteri as to render delivery easy; and then we either interfere or trust to natural expulsion, according to the briskness and force of the contraction, and state of the patient.

By this treatment, we obtain all the advantage that can be derived from the operations of nature, and, where these fail, are enabled to look with confidence to the aid of artificial delivery.

But it may happen that we have not had an opportunity of restraining the hemorrhage early; we may not have seen the patient until she has suffered much from the bleeding.\* In this case, we shall generally be obliged to deliver, and must upon no account delay too long; yet, if the os uteri be very firm, and without disposition to open, we shall generally find that the sinking is temporary: we may still trust for some time to the plug.

Hemorrhage is naturally restrained by faintness. A repetition is checked in the same way; and faintness takes place sooner than formerly. In one or two attacks, the uterus suffers, and the os uteri becomes dilatable. Slight pains come on, or are readily excited by attempts to distend the os uteri. Syncope then will, in general, even when the plug has not been used, and the patient has been neglected, restrain hemorrhage, and prevent it from proving fatal until the os uteri has relaxed; but a little delay beyond that period will destroy the patient; and it is possible, by giving wine, and otherwise treating her injudiciously, to make hemorrhage prove fatal, even before this takes place. But although I have considered it as a general rule, that where the os uteri

\* We are not to confine our attention to the quantity which has been lost, but to the effect it has produced; and this will *ceteris paribus* be great in proportion as the hemorrhage has been sudden.



is firm and unyielding, we may, notwithstanding present alarm, trust some time to the plug. Yet I beg it to be remembered, that there may be exceptions to this rule; for the constitution may be so delicate, and the hemorrhage so sudden, or so much increased by stimulants, as to induce a permanent effect, and make it highly desirable that delivery should be accomplished; but such instances are rare; and although I have spoken of the effects of syncope in restraining hemorrhage, I hope it will not be imagined by the student that I wish to make him familiar with this symptom. It is very seldom safe, when we have our choice, to wait till syncope be induced; and if it have occurred, it is not usually, prudent to run the risk of a second attack.

The old practitioners, not aware of the value of the plug, nor acquainted with the sound principles of physiology, had no fixed rule relating to delivery, but endeavoured to empty the uterus early; but it was uniformly a remark, that those women died who had the os uteri firm and hard.\* What is this but to declare, that the rash and premature operation is fatal? It is an axiom which should be deeply engraved on the memory of the accoucheur, and which should constantly influence his conduct. Pain and suffering are the immediate consequence of the practice; whilst a repetition of the flooding after delivery, or the accession of inflammation, are the messengers of death.

It was the fatal consequence of this blind practice that suggested to M. Puzos the propriety of puncturing the membranes, and thus endeavouring to excite labour. His reasoning was ingenious: his proposal was a material improvement on the practice which then prevailed. The ease of the operation, and its occasional success, recommend it to our notice; but experience has now determined that it cannot be relied on, and that it may be dispensed with. If we use it early, and on the first attack, we do not know when the contraction may be established; for, even in a healthy uterus, when we use it on account of a deformed pelvis, it is sometimes several days before labour be produced. We cannot

\* Vide the works of Mauriceau, Feu, &c.

say what may take place in the interval. The uterus being slacker, the hemorrhage is more apt to return, and we may be obliged after all to have recourse to other means, particularly to the plug. Now we know that the plug will, without any other operation, safely restrain hemorrhage, until the os uteri be in a proper state for delivery.\* The proposal of M. Puzos then is, I apprehend, inadmissible before this time: If after this there be occasion to interfere, it is evident that we must desire some interference which can be depended on, both with respect to time and degree. This method can be relied on in neither; for we know not how long it may be of exciting contraction, nor whether it may be able to excite effective contraction after any lapse of time. If it fail, we render delivery more painful, and consequently more dangerous to the mother, and bring the child into hazard. It has been observed, in objection to this, by Dr Denman†, that if turning be difficult, the flooding will be stopped by the contraction of the womb. But we know that the uterus, emptied of its water, may embrace the child so closely as to render turning, if not difficult, at least painful, and yet not be acting so briskly as to restrain flooding: nothing but brisk contraction can save a patient in flooding, if the vessels be large or numerous.

The only case then which remains to be considered, is that in which pains come on, and expulsion is going forward. Now, in this case, the flooding is stopped either by the contraction or by the plug, and the membranes burst in the natural course of labour; after which it is speedily concluded. Here, then, interference is not required; but if, after going on in a brisk way for some time, the pains abate a little, which often happens even in a natural labour, it will be pro-

\* The ingenious M. Alphonse Le Roy seems much inclined to trust almost entirely to the plug, and supposes that the blood will act as a foreign body, and excite contraction; but this, as a general doctrine, must be greatly qualified. Respecting the proposal of M. Puzos, he observes, "Puzos, en conseillant assez hardiment de percer les eaux, n'avoit d'autres vues que la contraction de la matrice, qui est la suite de cette operation et la cessation de la perte, et il la conseilla même dans les cas des pertes qui arrivent avant terme. Mais un grand nombre de femmes sont peries par l'effect de cette même pratique." *Léçons sur les pertes de sang*, p. 45.

† Introduction to the Practice of Midwifery, vol. ii. p. 310.

per to rupture the membranes, if we have reason to think that a slight stimulus to the uterus would renew its action : and, in determining this, the practitioner must be influenced by the previous discharge ; for if the uterus have been much reduced by it in its vigour, it will be less under the influence of a stimulus ; and if, upon the present diminution of the pains, the flooding is disposed to return, I should think that we surely ought to trust rather to the hand, which can stimulate in the necessary degree, and finish the process with safety, than to a method which is much more uncertain and less under our command\*.

The proposal of M. Puzos then will, if this reasoning be just, be very limited in its utility. Its simplicity gave me at first a strong partiality in its favour ; and if I now have changed my opinion, I have given my reasons.

But there still remains a most important question to be answered. In those cases where the patient has been allowed to lose a great deal of blood frequently and suddenly, when the strength is gone, the pulse scarcely to be felt, the extremities cold, the lips and tongue without blood, and the eye ghastly, shall we venture to deliver the woman ? Shall we, by plugging, endeavour to prevent farther loss, and by nourishment and care recruit the strength ; or empty the uterus, and then endeavour to restore the loss ? We have only a choice of two dangers. The situation of the patient is most perilous, and I have in practice weighed the argument with that attention which the awful circumstances of the case required. I think myself justified in saying, that we give both the mother and child the best chance of surviving by a cautious delivery. For in these cases the uterus is almost torpid, it possesses no tonic contraction† ; the very

\* In those cases where the placenta presents, few practitioners would think of trusting to the evacuation of the liquor amnii ; they would deliver. If their delivery be considered as safe and proper in one species of flooding, it cannot be dangerous in the other ; and whenever interference in the way of operation is necessary, the security afforded by the introduction of the hand will much more than compensate for any additional pain. But even in this respect, the two operations are little different, if properly performed.

† The use of the plug cannot here certainly prevent farther loss of blood. For the uterus affords no resistance, the hemorrhage continues, and after death large coagula will be found within the womb.



continuance of the ovum within it is more than it can bear, and on the most favourable supposition, it will require many days before it could be brought into a state capable of contracting. The general system is completely exhausted, and cannot support its condition long. I have never known a woman live twenty-four hours in these circumstances.

On the other hand, I grant, that it is possible the woman may die in the act of delivery, or very soon after it; but if she can be supported for two days, we may have hopes of recovery. By a very slow and cautious delivery, and by endeavouring to excite the action of the uterus, so as to prevent discharge afterwards, we not only remove the irritation of the distended womb, but we likewise take away a receptacle of blood. During the contraction of the uterus, the blood in its sinuses will be thrown into the system, and tend to support it. Part, no doubt, will escape; but by keeping the hand in the uterus, by supporting the abdomen with a compress, and exciting the uterine action by cold applications to the belly, we may prevent a great loss. When to these considerations we add the additional chance which the child has for life, our practice, I apprehend, will, in this very hazardous case, be decided. When the pulse becomes firmer and fuller upon the contraction of the uterus, the risk from debility is diminished. A full dose of landanum ought to be given previous to delivery.

The remarks upon the subsequent management of the patient, I shall reserve until I come to consider the treatment of flooding, after delivery.

At one time it was supposed, that the placenta was, in every instance, attached originally to the fundus uteri, and that it could only be found presenting in consequence of having been loosened and falling down. This accident was supposed to retard the birth of the child, by stopping up the passage, and also was considered as dangerous on account of the flooding which attended it. On this account Dauter endeavoured to accelerate the delivery by tearing the placenta, or rupturing the membranes when they could be found. This was a dangerous practice, and very few survived when it was

employed. Mr Gifford and M. Levret\* were among the first who established it as a rule that the placenta did not fall down, but was from the first implanted over the os uteri: and the latter gentleman published a very concise and accurate view of the treatment to be pursued.

We know, that during the eighth month of gestation, very considerable changes take place about the cervix uteri. It is completely developed and expanded; and, in the ninth month, very little distance intervenes betwixt the ovum and the lips of the os uteri. These changes cannot easily take place without a rupture of some of the connecting vessels, for either the placenta does not adapt itself to the changes in the shape of the cervix; or, which happens more frequently, some slight mechanical cause, or action of the fibres about the os uteri, produces a rupture.

This rupture may doubtless take place at any period of pregnancy†, but it is much more frequent in the end of the eighth and beginning of the ninth month, than at any other time. But whether the separation happens in the seventh, eighth, or ninth month, the consequent hemorrhage is always profuse, and the effects most alarming. The quantity, but especially the rapidity of the discharge, very frequently produces a tendency to faint, or even complete syncope; during which the hemorrhage ceases, and the woman may continue for several days without experiencing a renewal of it. In some instances she is able to sustain many and repeated attacks, which may take place daily for some weeks. These, however, it is evident, cannot be very severe, and the strength must originally have been great. In other instances, the woman never gets the better of the first attack. It indeed

\* Je m'engage a prouver 1<sup>o</sup> que le placenta s'implante quelquefois sur la circonference de l'orifice de la matrice; c'est-a-dire, sur celui qui du col va joindre l'interieur de ce viscere, & non sur celui qui regarde de la vagin.

2<sup>do</sup>. Qu'en ce cas la perte de sang est inevitable dans les dernier tems de la grossesse.

Et 3<sup>o</sup>. Qu'il n'y a pas de voye plus sure pour remedier a cet accident urgent que de fair l'accouchement force.—L'art des Accouchemens, p. 343.

† In some cases, hemorrhage has taken place so early as the third month. By proper means this has been stopped, and the patient has continued well for some months, when the flooding has returned, and the placenta been discovered to present.

diminishes, but does not altogether leave her, and a slight exertion renews it in its former violence. But whether the patient suffer much or little in the first attack—whether she be feeble or robust, the practice must be prompt, and the most solemn call is made upon the practitioner for activity. The moment that a discharge of blood takes place, he ought to ascertain by careful examination the precise nature of the case, and must take instant steps for checking it, if nature have not already accomplished that event.

If the os uteri be firm and close in a first attack, we ought to use the plug, which will restrain the hemorrhage, and insure the present safety of the patient. If this practice have been immediately followed, she will in general soon recover, and the length of time for which she will remain free from a second attack, will depend very much upon the care which is taken of her; but sooner or later the attack must and will return. If the uterus have been injured in its action by the first attack, this will generally be attended with very slight dull pains, and we shall feel the os uteri more open and laxer than usual; but if the first and second discharges have been promptly checked, it may be later before those effects be perceived; but the moment that they are produced, we ought to deliver, and it should even be a rule, that where they are not likely soon to take place, and the discharge has been profuse and rapid, and produced those effects on the system which I have already pointed out, as the consequence of dangerous hemorrhage, we must not delay until pains begin to open the os uteri. Fortunately, we are not often obliged to interfere thus early; for by careful management, and the use of the plug, we can secure our patient.

Although I have said that we may wait safely until the os uteri begins to open, and asserted, that no woman can die from mere hemorrhage, before the state of the os uteri admit of delivery, I must yet add, on this important subject, that this state does not consist merely in *dilatation*, for it may be very little dilated; but in *dilatability*, we may safely deliver whenever the hand can be introduced without much force. A forcible introduction of the hand on the first attack



of hemorrhage, would, in many cases, be attended with the greatest danger, and in almost every case is improper and unnecessary. I have never yet seen an instance, where delivery was required during the first paroxysm, if the proper treatment was followed. Whether it may be required in a second or third attack, or even later, must depend upon the quantity and rapidity of the discharge, its effects and the strength of the woman. But whenever we find the os uteri soften, and in any degree more open than in its usual state, and it admits the finger to be introduced easily within it, we may deliver safely; and if the hemorrhage be continuing, ought not to delay. This state will generally be found accompanied with obscure pains; but we attend less to the state of pains, than of discharge, in determining on delivery. The pains gradually increase for a certain period, and then go off. During their continuance, the os uteri dilates more; but if the hemorrhage have been, or continues to be considerable, we must not wait until the os uteri be much dilated, as we thus reduce the woman to great danger, and diminish the chance of her recovery. A prudent practitioner will not, on the one hand, violently open up the os uteri at an early period, but will use the plug, until the os uteri becomes soft and dilatable; and if the hemorrhage be not considerable, he will even, if the state of the patient allow him, wait until slight pains have appeared, or the os uteri begun sensibly to open without them; for he will recollect, that the more violence that is done to the os uteri, the greater is the risk of bad symptoms supervening. It is an error into which some have fallen, who look upon debility from discharge, as the only barrier to recovery. Violent delivery may produce inflammation, or a very troublesome fever. On the other hand, he will not allow his patient to lose much blood, or have many attacks; he will deliver her immediately for he knows that whenever this is necessary it is easy, the os uteri yielding to his cautious endeavours.

But very frequently we are not called until the patient has had one or two attacks, and been reduced to great danger. We find her with feeble pulse, ghastly countenance,

frequently vomiting, and occasionally complaining of slight grinding pains. On examination, the vagina is so filled with clotted blood, which adheres so firmly by the lymph to the uterus, that at first we find some difficulty in discovering the os uteri. We cannot here hesitate a moment what course to follow. If the patient is to be saved, it is by delivery. The os uteri will be in part dilated; it will easily be fully opened. We perhaps find an edge of the placenta projecting into the vagina, perhaps the centre of the placenta presenting or protruding like a cup into the vagina; but in those cases the rule is the same. We pass by the placenta to the membranes, rupture them\*, and turn the child, delivering according to the directions which I have already given.

It may be supposed, that as the treatment is so nearly the same, it is not material that we distinguish whether the placenta or membranes present. But it is convenient to make a distinction, because in those cases where the placenta does not present, it is possible, in certain circumstances, to cure the flooding, and carry the patient to the full time; and in those cases, which are indeed the most numerous, where this cannot be done, we always look to uterine contraction as a very great assistance, and expect that where that is greatest, the danger will be least. But when the placenta presents, we have no hope of conducting the woman safely to the full time. We have no ground to look to contraction or labour-pains as a mean of safety; for, on the contrary, every effort to dilate the os uteri separates still more the placenta, and increases the hemorrhage†. The very circumstance which in some other cases would save the patient, will here in general increase the danger. I say in general, for there are doubtless examples where the patient has by labour been safely and without assistance delivered of the child, when part of the placenta has presented. Nay, there have been instances

\* This is much safer for the child than pushing the hand through the placenta; and it is equally advantageous for the mother, and easy to the operator.

† The greatest number of profuse or alarming hemorrhages proceed from the presentation of the placenta, or the implication of its margin over the os uteri; and, consequently, the greatest number of cases requiring delivery are of this kind.

where the placenta has been expelled first, and the child after it\*. These examples are to be met with in collections of cases by practical writers; and some solitary instances are likewise to be found in different journals. It would be much to be lamented if these should ever appear without having at the same time a most solemn warning sent along with them to the accoucheur, to pay no attention to them in his practice†. I am convinced that they may do inexpressible mischief by affording argument for delay, and excusing the practitioner to himself for procrastination. There is scarcely any malady so very dreadful as not to afford some examples of a cure effected by the powers of nature alone; but ought we thence to tamper with the safety of those whose lives are committed to our charge? Ought we to neglect the early and vigorous use of an approved remedy, because the patient has not in every instance perished from the negligence of the attendant? It is highly proper to publish the case of a patient who, from hernia, has had an anus formed at his groin, because it adds to our stock of knowledge: But what should we think of a surgeon who should put such a case into the hands of a young man, without, at the same time, saying, "Sir, if such a case ever happen in your practice, either you or your patient will be very much to blame." I do not mean from this to say, that we are to blame, in every instance, the accoucheur who has attended a case where the placenta has presented; and the patient been delivered by nature; far from it, for by the use of the plug, he may have restrained the hemorrhage, pains may have come on, and the child, descending, may have carried the plug before it: or, when he was called to his patient, he may have found her already in labour, and the process going on so well and so safely, that all interference would have been injudicious. But these instances are not to be converted into general rules, nor allowed to furnish any pretext for procrastination. They

\* Even in those cases where the placenta is expelled first, the flooding may recur, and the woman die, if she be not assisted. Vide La Motte. Obs. cexxxviii, & cexxxix.

† Most of those who have met with such cases, do not seem to count much upon them.



happen very seldom, and never ought to be related to a young man without an express intimation that he is not to neglect delivery, when it is required, upon any pretence whatsoever.

#### SECTION THIRTY-SEVENTH.

Many women are subject, in the end of gestation, to pains about the back or bowels, somewhat resembling those of labour, but which, in reality, are not connected with it. These, therefore, are called false pains. They sometimes only precede labour a few hours; but in many cases, they come on several days, or even some weeks, before the end of pregnancy, and may be very frequently repeated, especially during the night, depriving the woman of sleep. They are often confined altogether to the belly, shifting their place, and being very irregular both in their attacks and continuance. In some cases they affect the side, particularly the right side, in the region of the liver, and are exceedingly severe, especially in the evening; they are accompanied with acidity or water-brash, or reaching, and generally the child is at that time very restless. These pains may doubtless occur in any habit, but they chiefly harass those who are addicted to the use of cordials. On other occasions, the false pains occupy chiefly the back or hips, or upper part of the thighs. They even sometimes resemble still more nearly parturient pains, in being attended with an involuntary effort on the part of the abdominal muscles, to press down, so as to make the woman suppose that she is about to be delivered; and this is occasionally accompanied with tenesmus, or with protrusion of the bladder from the vagina, very like the membranes of the ovum. In other cases, they are attended with a discharge of watery fluid from the vagina. False pains may be occasioned by many causes: the most frequent are flatulence; a spasmodic state of the bowels, resembling slight cholic; or irritation, connected with costiveness or diarrhoea; or nephritic affections, often accompanied with strangury. A sudden motion of the back, or unusual degree of fatigue, may cause a remitting pain in the back and loins; or getting sud-

denly out of bed when warm, and placing the feet in the cold floor, may have the same effect. A slight degree of lumbago may also resemble the parturient pains. Agitation of mind, or a febrile state of the body, or some irritation in the neighbourhood of the uterus, or some unusual motion of the child, may produce an uneasy sensation in the uterus; and sometimes this is accompanied by a discharge of watery fluid from the vagina.

False pains may often be distinguished by their situation; as for instance, when they affect the bowels or kidneys; by their shifting their situation; by their duration; by their irregularities; and by the symptoms with which they are attended. But the best criterion is, that they seldom affect the os uteri, that part not being dilated during their continuance. It is necessary however to observe, that a dilated state of the os uteri does not always prove that the pains are of those labour; for it may be found prematurely dilated for a week or two before the proper term of labour, without any pain. In this case, if the pains proceed from affections of the bowels, no effect is produced during the pain, in rendering the os uteri tense, or making it larger. On the other hand, it sometimes happens; that the fibres about the os uteri are prematurely irritated; and this state may be accompanied with pain, and with a perceptible change on the os uteri during a pain. This is a very ambiguous case; but we may be assisted in our judgment, by discovering, that the term of utero-gestation is not completed, that the os uteri is hard or thick, and the pains irregular. In all such cases, it is best to proceed on the supposition, that the woman is not actually in labour; for by letting her alone, she most likely will have a continuance of pain, terminating, it is true, in labour, but the process will be tedious and fatiguing; whereas, by suspending the action by an opiate, and if necessary by venesection, the woman may go on for some time longer, and will at all events have an easier delivery.

When the false pains are accompanied with a febrile state, or are very distressing during the night, it will be proper to detract blood, and afterwards give an anodyne. In all other

cases, it is generally sufficient to keep the woman in a state of rest, prescribe an opiate, and if necessary, open the bowels by means of a clyster. Rubbing with anodyne balsam is also useful.

Shivering and tremor occur in some cases; in the end of pregnancy; and as they also occasionally precede labour, they often give rise to an unfounded expectation, that delivery is approaching. They appear to be connected sometimes with the state of the stomach, or alimentary canal; in other instances with some change in the os uteri itself, which, even without pain, may be so far opened or relaxed as to allow the finger very easily to touch the child's head through the membranes. It is usually in the evening, or through the night, that the shivering is felt; and it is occasionally pretty severe, and may be several times repeated. Nothing, however, is required, except a little warm gruel, or a moderate dose of laudanum, which is always effectual.

## BOOK II.

### Of Parturition.

#### CHAP. I.

##### *Of the Classification of Labours.*

**LABOUR** may be defined to be the expulsive effort made by the uterus for the birth of the child, after it has acquired such a degree of maturity, as to give it a chance of living, independently of its uterine appendages.

I propose to divide labours into seven classes; but I do not consider the classification to be of great importance, nor one mode of arrangement much better than another, for the purposes of practice, provided proper definitions be given, and plain rules delivered, applicable to the different cases.



The classels which I propose to explain are,

CLASS I. *Natural Labour*; which I define to be labour taking place at the end of the ninth month of pregnancy; the child presenting the vertex, and the forehead being directed at first toward the sacro-iliac symphysis; a due proportion existing betwixt the size of the head, and the capacity of the pelvis; the pains being regular and effective; the process not continuing beyond twenty-four hours, seldom above twelve, and very often not for six. No morbid affection supervening, capable of preventing delivery, or endangering the life of the woman.

This comprehends only one order.

CLASS II. *Premature Labour*, or labour taking place considerably before the completion of the usual period of uterogestation, but yet not so early as necessarily to prevent the child from surviving.

This comprehends only one order.

CLASS III. *Preternatural Labours*, or those in which the presentation, or position of the child is different from that which occurs in natural labour; or in which the uterus contains a plurality of children.

This comprehends seven orders.

ORDER 1. Presentation of the breech.

ORDER 2. Presentation of the inferior extremities.

ORDER 3. Presentation of the superior extremities.

ORDER 4. Presentation of the back, belly, or sides of the child.

ORDER 5. Malposition of the head.

ORDER 6. Presentation of the funis.

ORDER 7. Plurality of children.

CLASS IV. *Tedious Labour*, or labour protracted beyond the usual duration; the delay not caused by the malposition of the child, and the process capable of being finished safely, without the use of extracting instruments.

This comprehends two orders.

ORDER 1. Where the delay proceeds from some imperfection or irregularity of muscular action.

ORDER 2. Where it is dependent principally on some mechanical impediment.

CLASS V. *Laborious or Instrumental Labour*; labour which cannot be completed without the use of extracting instruments; or altering the proportion betwixt the size of the child, and the capacity of the pelvis.

This comprehends two orders.

ORDER 1. The case admitting the use of such instruments as do not necessarily destroy the child.

ORDER 2. The obstacle to delivery being so great, as to re-

quire that the life of the child should be sacrificed for the safety of the mother.

CLASS VI. *Impracticable Labour*; labour in which the child, even when reduced in size, cannot pass through the pelvis.

This comprehends only one order.

CLASS VII. *Complicated Labour*; labour attended with some dangerous or troublesome accident or disease, connected in particular instances with the process of parturition.

This comprehends six orders.

ORDER 1. Labour complicated with uterine hemorrhage.

ORDER 2. Labour complicated with-hemorrhage from other organs.

ORDER 3. Labour complicated with syncope.

ORDER 4. Labour complicated with convulsions.

ORDER 5. Labour complicated with rupture of the uterus.

ORDER 6. Labour complicated with suppression of urine, or rupture of the bladder.

Calculations have been made, of the proportion which these different kinds of labour bear to each other in practice. Thus Dr Smellie supposes, that out of a thousand women in labour, eight will be found to require instruments, or to have the child turned, in order to avoid them; two children will present the superior extremities; five the breech; two or three the face; one or two the ear; and ten will present with the forehead turned to the acetabulum.

Dr Bland has, from an hospital register, stated the proportion of the different kinds of labour, to be as follows: of 1897 women, 1792 had natural labour. Sixty-three, or one out of 30, had unnatural labour; in 18 of these, the child presented the feet, in 36, the breach, in 8, the arm, and in 1 the funis. Seventeen, or one out of 111 had laborious labour; in 8 of these, the head of the child required to be lessened, in 4 the forceps were employed, and in the other 5, the face was directed toward the pubis. Nine, or one in 210, had uterine hemorrhage before or during labour. It is evident, however, that this register cannot form a ground for general calculation; and the reader will perceive, that the number of crotchet cases exceeds those requiring the forceps, which is not observed in the usual course of practice.

We cannot form an estimate of the proportion of labours, with much accuracy, from the practice of individuals, as one

man may, from particular circumstances, meet with a greater number of difficult cases, than is duly proportioned to the number of his patients. Thus Dr Hagen of Berlin says, that out of 350 patients, he employed the forceps 93 times, and the crotchet in 28 cases; 26 of his patients died. Dr Dewees again, of Philadelphia, says, that in more than 3000 cases, he has not met with one requiring the use of the crotchet.

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## CHAP. II.

### *Of Natural Labour.*

#### SECTION FIRST.

PREVIOUS to the accession of labour, we observe certain precursory signs, which appears sometimes for several days, oftener only for a few hours before pains be felt. The uterine fibres begin slowly and gradually to contract or shorten themselves, by which the uterus becomes tenser and smaller. It subsides in the belly, the woman feels as if she carried the child lower than formerly, and thinks herself slacker and less than she was before. For some days before gestation be completed, she in many cases is indolent and inactive, but now she often feels lighter and more alert. At the same time that the uterus subsides, the vagina and os uteri are found to secrete a quantity of glairy mucus, rendering the organs of generation moister than usual; and these are somewhat tumid and relaxed, the vagina especially becoming softer and more yielding. These changes are often attended with a slight irritation of the neighbouring parts, producing an inclination to go to stool, or to make water frequently, and very often griping precedes labour, or attends its commencement.

The intention of labour is, to expel the child and secundines. For this purpose, the first thing to be done, is to dilate, to a sufficient degree, the os uteri, so that the child may pass through it. The next point to be gained, is the expulsion of the child itself: and last of all, the foetal appen-



dages are to be thrown off. The process may therefore be divided into three stages. The first stage is generally the most tedious. It is attended with frequent, but usually short pains, which are described as being sharp, and sometimes so severe, as to be called cutting or grinding. They commonly begin in the back, and extend toward the pubis or top of the thighs; but there is, in this respect, a great diversity with different women, or the same woman at different times. Sometimes the pain is felt chiefly or entirely in the abdomen, the back being not at all affected during this stage; and it is generally observed, that such pains are not so effective as those which affect the back. Or the pain produced by the contraction of the womb may be felt in the uterine region; and when it goes off, may be succeeded by a distressing aching in the back. In other cases, the pain is confined to the small of the back, and upper part of the sacrum; and is either of a dull aching kind, or sharp and acute, and, in some instances, is attended with a considerable degree of sickness, or tendency to syncope. The most regular manner of attack, is for the pains to be at first confined to the back, descending lower by degrees, and extending round to the belly, pubis, or top and fore part of the thighs, and gradually stretching down the back part of the thighs, the fore part becoming easy; occasionally one thigh alone is affected. At this time also, one of the legs is sometimes affected with cramp. The duration of each pain is variable; at first it is very short, not lasting above half a minute, perhaps not so long, but by degrees it remains longer, and becomes more severe. The aggravation, however, is not uniform, for sometimes in the middle of the stage, the pains are shorter, and more trifling than in the former part of it. During the intermission of the pains, the woman sometimes is very drowsy, but at other times is particularly irritable and watchful.

The pains of labour often begin with a considerable degree of chillness; or an unusual shaking or trembling of the body, with or without a sensation of coldness. These tremors may take place, however, at any period of labour; they may usher in the second stage, and be altogether wanting

during the first ; or they may not appear at all, even in the slightest degree ; or they may be present only for a very short time. They do not generally precede the uterine pain, but may be almost synchronous in their attack : in other cases, they do not appear until the pain has lasted for a short space of time ; but whenever they do come on, it is usual for the uterine pain to be speedily removed. Hence it might be supposed, that they should materially retard labour, but this is far from being always the case. In degree, they vary from a gentle tremor to a concussion of the frame, so violent as to shake the bed on which the patient rests, and even to bear some resemblance to a convulsion. The stomach also sympathises with the uterus during this stage, the patient complaining of a sense of oppression ; sometimes of heart-burn or sickness, or even of vomiting, which is considered as a good symptom, when it does not proceed from exhaustion ; or of a feeling of sinking or faintness, but the pulse is generally good. When there is in a natural labour, a sudden attack of sickness, faintishness, and feeble pulse, the patient is generally soon relieved by vomiting bile. These symptoms, however, are often wanting, or attack at different periods of labour : like the rigours, they may be absent during the greatest part of the first stage, or until its end, ushering in the second ; but in general, they are confined to the first stage, going off when the os uteri is fully dilated. In consequence, partly of those feelings, partly of the anxiety and solicitude connected with a state of suffering and danger, and partly from the pains being free from any sensation of bearing-down, the woman, during this stage, is apt to become desponding, and sometimes fretful. She supposes that the pains are doing no good ; that she has been, or is to be, long in labour ; that something might be done to assist her, or has been done, which had better have been avoided ; and that there is a wrong position of the child, or deficiency of her own powers.

When the pains of labour begin, there is an increased discharge of mucus from the vagina, which proceeds from the vaginal lacunæ, and from the os uteri. It is glairy, whit-

ish, and possesses a peculiar odour. When the os uteri is considerably dilated, though sometimes at an earlier period, there is, in consequence of the separation of the decidua, a small portion of blood discharged, which gives a red tinge to the mucus.

The distension of the os uteri is often attended with irritation of the neighbouring parts, the woman complaining of a degree of strangury; or having one or two stools with or without griping, especially in the earlier part of the stage. The pulse generally is somewhat accelerated.

The os uteri being considerably dilated, the second stage begins. The pains become different, they are felt lower down; they are more protracted, and attended with a sense of bearing down, or an involuntary desire to expel or strain with the muscles; and this desire is very often accompanied with a strong inclination to go to stool. A perspiration breaks out, and the pulse, which during the first stage beat rather more frequently than usual, becomes still quicker; the woman complains of being hot, and generally the mouth is parched. Soon after the commencement of this stage, it is usual for the liquor amnii to be discharged. This is often followed by a short respite from pain, but presently the efforts are redoubled. Sometimes there is no cessation, but the pains immediately become more severe, and sensibly effective. The perinæum now begins to be pressed outward, and the labia are put upon the stretch. The protrusion of the perinæum gradually increases, but it is not constant; for when the pain goes off, the head generally recedes a little, and the perinæum is relaxed. Presently the head descends so low, that the parts are kept permanently on the stretch, and the anus is carried forward. Then the vertex pressing forward, the labia are elongated, and the orifice of the vagina dilated. The perinæum is very thin, much stretched, and spread over the head of the child. As the head passes out, the perinæum goes back over the forehead, becoming narrower, but still more distended laterally. If the perinæum did not move backward as the head moved forward, it would run a greater risk of being torn; and indeed, even in the most regularly conducted labour, a part of it is often rent. Delivery of the head is



accomplished with very severe suffering; but immediately afterwards, the woman feels easy, and free from pain. In a very little time, however, the uterus again acts, and the rest of the child is expelled, which completes the second stage of labour. The expulsion of the body is generally accomplished very easily, and quickly; but sometimes the woman suffers several strong and forcing pains, before the shoulders are expelled. The birth of the child is succeeded, after a short calm, by a very slight degree of pain, which is consequent to that contraction which is necessary for the expulsion of the placenta. This expulsion is accompanied and preceded by a slight discharge of blood, which is continued, but in decreasing quantity, for a few days, under the name of the red lochia.

#### SECTION SECOND.

The duration of this process, and of its stages, varies not only in different women, but in the same individual in successive labours; for although some, without any mechanical cause, be uniformly slow or expeditious, others are tedious in one labour, and perhaps extremely quick in the next, and this variation cannot be foreseen from any previous state of the system. A natural labour ought to be finished within 24 hours after the first attack of pain, provided the pains be truly uterine, and are continued regularly; for occasionally, after being repeated two or three times, they become suspended, and the person keeps well for many hours, after which the process begins properly. In such cases, the labour cannot be dated from the first sensation of pain, nor deemed tedious. The greatest number of women do not complain for more than 12 hours, many for a much shorter period, and some for not more than one hour. Few women call the accoucheur, until, from the regularity and frequency of the pains, they are sure that they are in labour, and feel themselves becoming worse. As the celerity of the process cannot be previously determined, many women thus bear their children alone, becoming rapidly and unexpectedly worse. On an average, it will be found, that in natural labour, the accoucheur is not called above four hours previous to delivery.

The regularity and comparative length of the different stages is also various; but it will be generally observed, that when a woman has a natural labour protracted to its utmost extent, the delay takes place in the first stage; and in those cases where the second stage is protracted, the delay occurs in the latter end of that stage. In most cases, the first stage is triple the length of the second. The first stage may be tedious, from the pains not acting properly on the os uteri, or being weak and inadequate to the effect intended, or becoming prematurely blended with the second stage; that is to say, bearing down efforts being made, before the os uteri be much dilated. Various circumstances may conspire to produce this delay, such as debility of the uterus, rigidity of its mouth, premature evacuation of the water, improper irritation, injudicious voluntary effects, &c. The second stage may be tedious, from irregularity of the uterine contraction or from a suspension of the bearing-down efforts, or from the head not turning into the most favourable direction, or from the rigidity of the external organs.

These, and other causes, which will hereafter be considered, may not only protract the labour, but may even render it so tedious, as to remove it from the class of natural labours altogether. It is a general opinion, that a first labour is always more lingering than those which succeed. We should be led, however, to suppose, that parturition, being a natural function, ought to be as well and as easily performed the first time, as the fifth; the process not depending upon either habit or instruction. But we do find, that here, as in many other cases, popular opinion is founded on fact; for although in several instances, a first labour is as quick as a second, yet in general, it is longer in both its stages. This, perhaps, depends chiefly on the facility with which the different soft parts dilate after they have been once fully distended. Some have attributed the pain of parturition to mechanical causes, ascribing it to the shape of the pelvis, and the size of the child's head. But this is not the case, for in a great majority of cases, the pelvis is so proportioned, as to permit the head to pass with

great facility. The pain and difficulty attending the expulsion of the child in natural labour, are to be attributed to the forcible contraction of the sensible fibres of the uterus, and to the dilatation of the os uteri and vulva, in consequence thereof. Women will therefore, *ceteris paribus*, suffer in proportion to the sensibility of the organs concerned, and the difficulty with which the parts dilate. In proportion as we remove women from a state of simplicity to luxury and refinement, we find that the powers of the system become impaired, and the process of parturition is rendered more painful. In a state of natural simplicity, women in all climates bear their children easily, and recover speedily<sup>1</sup>; but this is more especially the case in those countries where heat conspires to relax the fibres. The quality or quantity of the food has much less influence than the general habit of life, upon the process of parturition. In a savage state, women, though living abstemiously, and often compelled to work more than men, bear children with facility; whilst in this country, women who live on plain diet are not easier than those who indulge in rich viands.

### SECTION THIRD.

The existence and progress of labour, and the manner in which the child is placed, are ascertained by examination per vaginam. For this purpose the woman ought to be placed in bed, on her left side\*, with a counterpane thrown over her, if she be not undressed. The hand is to be passed along the back part of the thighs to the perinæum, and thence immediately to the vagina, into which the fore finger is to be introduced. It never ought to be carried to the fore part of the vulva, and from that back to the vagina. The introduction is to be accomplished as speedily and gently as possible, and the greatest delicacy must be observed. The information which we wish to procure is then to be obtained by a

\* A standing or half-sitting position has been proposed by some, and may doubtless in certain diseases of the uterus be proper, that it may, by its weight, come within reach. Sometimes in the early months of pregnancy, it is allowable from the same motives; but, during labour, it is not often that the uterus is so high that the examination cannot be performed in a recumbent posture.



very perfect, but very cautious examination of the os uterí, and presenting part of the child, which gives no pain, and consequently removes the dread which many women, either from some misconception, or from previous harsh treatment, entertain of this operation.

When a woman is in labour, we should, if the pains be regular, propose an examination very soon after our arrival.

It is of importance that the situation of the child be early ascertained, and most women are anxious to know what progress they have made, and if their condition be safe. As it is usual to examine during a pain, many have called this operation "taking a pain;" but there is no necessity for giving directions respecting the proper language to be used, as every man of delicacy and sense will know how to behave, and can easily, through the medium of the nurse, or by turning the conversation to the state of the patient, propose ascertaining the progress of the labour. Some women, from motives of false delicacy, and from not understanding the importance of procuring early information of their condition, are averse from examination until the pains become severe. But this delay is very improper; for, should the presentation require any alteration, this is easier effected before the membranes burst than afterwards. When the presentation is ascertained to be natural, there is no occasion for repeated examinations in the first stage, as this may prove a source of irritation, and, should the stage be tedious, may be a mean of exciting impatience. In the second stage, the frequency of examination must be proportioned to the rapidity of the process.

In order to avoid pain and irritation, it is customary to anoint the finger with oil or pomatum; but unless this practice be used as a precaution to prevent the action of morbid matter on the skin, it is not very requisite, the parts being, in labour, generally supplied with a copious secretion of mucus. It is usual for the room to be darkened, and the bed curtains drawn close, during an examination; and the hand should be wiped with a towel, under the bed-clothes, before it be withdrawn. The proper time for examining is during

a pain ; and we should begin whenever the pain comes on. We thus ascertain the effect produced on the os uteri, and, by retaining the finger until the pain goes off, we determine the degree to which the os uteri collapses, and the precise situation of the presenting part, which we cannot do during a pain, if the membranes be still entire, lest the pressure of the finger should, were they thin, prematurely rupture them.

An examination should never, if possible, be proposed or made whilst an unmarried lady is in the room, but it is always proper that the nurse or some other matron be present.

The existence of labour is ascertained by the effects of the pains on the os uteri ; and its progress, by the degree to which it is dilated, and the position of the head with regard to different parts of the pelvis.

Before labour begins, the os uteri is generally closed, and directed backwards toward the sacrum. When we examine in the commencement of labour, the os uteri is to be sought for near the sacrum, at the back part of the pelvis, whilst between that spot and the pubis, we can pass the finger along the fore part of the cervix uteri. On this the presenting part of the child rests, so that, in natural labour, it assumes somewhat the shape of the head ; and, for the sake of distinction, I shall call it the uterine tumor. In some, it is so firmly applied to the head, and so tense, that a superficial observer would take it for the head itself. In this case the labour often is lingering. This tumor, or portion of the uterus, is broad in the beginning of labour, but becomes narrower as the os uteri dilates, until at last it is completely effaced, the head either naked or covered with the membranes, occupying the vagina. The breadth of this portion of the uterus, therefore, as well as the examination of the os uteri, will serve to ascertain the state of the labour.

The os uteri gradually dilates by the pains of labour, but this dilatation is easier effected in some cases than in others. In some, though the pains have lasted for many hours, and have been frequent, the os uteri will be found still very little opened. In others, a very great effect is produced in a

short time; nay, we even find, that the os uteri may be partly dilated without any pain at all. We cannot exactly foretell the effect which the pains may have by any general rule.

We find, in different women, the os uteri in very opposite states. In some it is thick, soft, and protuberant; in others, thin and tubulated; sometimes it is not prominent, but the edges of the mouth are on the same plane, like the mouth of a purse: these edges may be thin or thick, and both these states may exist with hardness or softness of the fibre. In some cases, they seem to be swelled, as if they were œdematous, and this state is often combined with œdema of the vulva. Now, of these conditions, some are more favourable than others; a rigid os uteri, with the lips either flat or prominent, is generally a mark of slow labour, for as long as this state continues, dilatation is tardy; a thick œdematous feel of the os uteri is also unfavourable; and usually a projecting or tubulated mouth, especially if the margin be thick and hard\*, is connected with a more tedious labour than where the os uteri is flat. In some cases of slow labour, the os uteri for many hours is scarcely discernible, resembling a dimple or small hard ring, perfectly level with the rest of the uterus. But although these observations may assist the prognosis, yet we never can form an opinion perfectly correct; for it is wonderful how soon a state of the os uteri, apparently unfavourable, may be exchanged for one very much the reverse, and the labour may be accomplished with unexpected celerity. Our prognosis, therefore, should be very guarded. When the pains produce little apparent effect on the os uteri, when they are slight and few, and when the orifice of the uterus is hard and rigid, or thick and puckered during a pain, there is much ground to expect that the labour may be lingering; on the other hand, when the pains are brisk, the os uteri thin and soft, we may expect a more speedy delivery: but as in the first case, the unfavourable state of the os uteri may be unexpectedly removed, so in the

\* If the margin be thin and soft, the os uteri sometimes, in the course of an hour, loses its projecting form, and becomes considerably dilated.



second, the pains may become suspended or irregular, and disappoint our hopes. The os uteri seldom dilates equally in given times, but is more slow at first in opening than afterwards. It has been supposed, that if it require three hours to dilate the os uteri one inch, it will require two to dilate it another inch, and other three to dilate it completely. This calculation, however, is subject to great variation, for in many cases, though it require four hours to dilate the os uteri one inch, a single hour more may be sufficient to finish the whole process.

The os uteri is, in the beginning of labour, generally pretty high up; but as the process advances, the uterus descends in the pelvis, along with the head; and, in proportion as it descends, the os uteri dilates, whilst the uterine tumor diminishes in breadth. Should the os uteri remain long high, even although it be considerably dilated, but more especially if it be not, there is reason to suppose that the labour will be continued still for some time. On the other hand, should the uterus descend too rapidly, there may be a species of prolapsus induced, the os uteri appearing at the orifice of the vagina. This state is generally attended with premature bearing-down pains, and indicates a painful, and rather tedious labour.

The protrusion of the membranes, and discharge of the liquor amnii, ought to bear a certain relation to the advancement of labour. Whilst the os uteri is beginning to dilate, the membranes have little tension; they scarcely protrude through the os uteri, until it be considerably opened. But in proportion as the dilatation advances, and the pains become of the pressing kind, the membranes are rendered more tense, protruding during a pain, and becoming slack, and receding when it goes off. In some cases, by examination, we find the membranes forced out very low into the vagina, like a segment of a bladder, tense and firm, during a pain, but disappearing in its absence. Sometimes, although the head be so high as not to touch the perinæum, the membranes protrude the perinæum, and the fæces are evacuated or pressed out, as if the head were about to be expelled. When the

membranes burst, the head is in such cases often delivered in a few seconds; but the pains may remit for a short time, and the woman be easier than formerly. The protrusion of the membranes, which has been described by some as constituting a part of a natural labour, is by no means an universal occurrence; for in numerous instances the membranes protrude very little, and scarcely form a perceptible bag in the vagina. When the pains have acted some time on the membranes, pushing the liquor amnii against them, and especially when they become pressing, the membranes burst, and the water escapes, sometimes in a considerable quantity; but in other cases, very little comes away, the head occupying the pelvis so completely, that most of the water is retained above it, and is not discharged until the child be born. If there be great irregularity in the degree to which the membranes protrude, there is no less in the period at which they break. In some cases, from natural feebleness or thinness, they break very early, and the liquor amnii comes away slowly. Sometimes they break in the middle or latter end of the first stage, in the commencement of the second, or not until the very end, when the head is about to be born. The opening is sometimes very large, and the head enlarging it, passes through it; at other times it is small, and the membranes are not perforated by the head, but they come along with it like a cap or cover. By examination, we ascertain the state of the membranes, and may be assisted in our judgment of the progress of the labour. When the membranes feel tense, and are protruded during a pain, we may be sure that the action of the uterus is brisk and good. When much water is collected beneath the head, forming a pretty large bag in the vagina; or when, during the pain, there is a tense protrusion of the membranes, though they be flat, forming a small segment of a large circle, we may expect, that if the pains continue as they promise to do, the membranes will soon burst, and the pains become more pressing. If during each pain, after the rupture, a quantity of water come away, it is probable, that whenever the uterus is pretty well emptied of the fluid, it will contract more

powerfully. Should the membranes break when the os uteri is not fully opened, perhaps only half dilated, we may, if there be a large discharge, expect a brisker action, and that the full dilatation of the os uteri will be soon accomplished; but if the water only ooze away, and the pains become less frequent, and not more severe, the labour may probably be protracted for some time.

In the first stage of labour, the head will be found placed obliquely along the upper part of the pelvis, with the vertex directed toward one of the acetabula. The finger can easily ascertain the sagittal, and afterwards the lamboidal suture; the sagittal suture is the point from which we set out, and, if the finger is readily led to the angle formed by the posterior edges of the parietal bones, we may be sure that the presentation is favourable. If, on the other hand, we can feel the anterior fontanelle, the vertex is generally directed to the sacro iliac articulation. When the pelvis is well formed, and the cranium of due size, the head may commonly be felt in every stage of labour; but there are cases, in which, even although the pelvis be ample, it is not easily touched for some time. Such instances, however, are rare; and whenever we are long of feeling the presentation, and do not discover a round uterine tumor, we may suspect that some other part of the child than the head presents. Even in the end of pregnancy, and long before labour begins, the head can usually be discovered resting on the distended cervix uteri; but different circumstances may for a time prevent it from being felt, the head perhaps in some cases, as from a fall for instance, being for a short time displaced towards one side.

In proportion as the head descends in the pelvis, the vertex is turned forward; so that, when the whole head has entered the pelvis, the face is thrown into the hollow of the sacrum, and the sagittal suture rests on the perinæum, whilst the occiput is placed under the symphysis pubis, or on its inside. This takes place earlier in one case than in another. In some, by the time that the scalp is at the orifice of the vagina, and the perinæum rendered rather full, the face is



thrown into the hollow of the sacrum. But in general, it will still be found, that the ear is near the pubis, and the turn is not completed till the perinæum is considerably stretched.

When the head comes to present at the orifice of the vagina, or passes a line drawn from the under edge of the symphysis pubis back to the sacrum, the perinæum and skin near the tuberosities of the ischia become full, as if swelled, but not tense. Whenever the fulness is felt, we may be sure that the head is descending; but although a few pains may protrude the perinæum, it may yet be some hours before this take place, the pains for all that time appearing to produce very little effect, although the pelvis be well formed: Should the perinæum become stretched, and the anus be carried forward a little during the pain, we may expect that delivery is at hand. If the woman has already born children, the child is sometimes delivered within a few minutes after the perinæum is first felt to become full.

When the pelvis is well formed, the head generally descends without much change of the scalp; but when it is contracted, or the head rests long on the perinæum, the scalp is either wrinkled, or protruded like a tumor filled with blood.

By examination, we ascertain the presentation; and the progress which the labour has made; but in forming an opinion respecting the probable duration of the process, we must be greatly influenced by the state of the pains, and in part also by our knowledge of former labours, if the woman have born many children. The different stages of labour are generally marked by a different mode of expressing pain. In the first stage, the pains are sharp, and the woman either moans or frets, or sometimes bears in silence. The second stage is marked by a sound, indicating a straining exertion, a kind of protracted groan, so that, by the change of the cry, a practitioner may often determine the stage of the labour. Sometimes in this stage, the woman clinches her teeth, or holds in her breath, so that she is scarcely heard to complain. In the moment of expelling the head, some women are quite

silent, or utter a low groan, others scream aloud. When the pains in the first stage are increasing in frequency, in severity, and in duration, and when they are accompanied with a corresponding dilatation of the os uteri, and especially when it, together with the head, gradually descends, the prognosis is very favourable. When the pains, after the os uteri is considerably dilated, become forcing, with an inclination to void the urine or fæces, and when these pains are accompanied with a full dilatation of the os uteri, the head at the same time descending lower, and the vertex beginning to turn round, we may look for a speedy delivery. But if the pains in the first stage be weak and few, and occur at long intervals, or, though not unfrequent, if they last only for a few seconds, and especially, if at the same time the os uteri be high up, or hard, or thick, we may conclude that the process is not likely to be rapid. If, when the os uteri is little dilated, there be an inclination to bear down, the labour is generally slow, and hence all attempts to press with the abdominal muscles are improper; for whether these be made voluntarily or involuntarily, they, during this stage, add to the suffering, fatigue the woman, produce a tendency to prolapsus uteri, so that, in some instances, the os uteri is forced to the orifice of the vagina, and render the labour always slow and severe.

When the head is brought so low as to protrude the perinaeum, the pains generally become more frequent and severe, and very soon effect the expulsion. But if they be forcing, and propel the head considerably each time, but it recedes completely thereafter, it is likely that the delivery of the head will be difficult and painful; for in some cases, the external parts are long of yielding, and require repeated efforts to distend them before the head can safely be expelled.

Sometimes the pains, after beginning regularly and briskly, become suspended, or less effective, and this alteration cannot be foreseen. It is a popular opinion, that if a woman be not delivered within twelve hours after she is taken ill, the labour will become brisker at the same hour at which

it began, that is to say, twelve hours after its commencement; and this opinion is, in many instances, countenanced by fact. In other cases, the labour becomes decidedly brisker six hours after its commencement. Most women begin to complain during the night, or early in the morning, and a great majority are delivered betwixt twelve at night and twelve o'clock noon.

#### SECTION FOURTH.

Different attempts have been made to explain why labour commenced at the end of the ninth month of pregnancy. The mysterious power of numbers, the influence of the planets, the distension of the uterine fibres, the pressure of the child upon the developed cervix and os uteri, have all in succession been enumerated, as affording a solution of the question. It can serve no good purpose to enter into the investigation. We know, that whenever the process of uterogestation is completed, the womb begins to contract. If, by any means, this process could be protracted, then labour would be kept off; and, on the other hand, if this process be stopped prematurely, either from some peculiarity connected with it, by which it is completed earlier than usual, or, from being interrupted by extraneous causes, acting either on the uterus, or by killing the child, then contraction does very soon commence. The immediate cause of the delivery of the child has been attributed to efforts made by the fœtus itself, the expulsive force of the abdominal muscles, or the contraction of the uterus. The first is fully set aside, by our finding, that the fœtus, when 'dead, is born *certieris paribus*, as easily as when it is alive and active. That the muscles alone cause the expulsion of the child, is disproved, by observing, that in the early part of labour they are perfectly quiescent, and no voluntary effort made with them is attended with any good effect. That the delivery is in a great measure owing to the action of the uterus, is proved by observing, that the uterus contracts in proportion as the delivery advances, and when the child is born, it is found to be very greatly diminished in size. But we have a still more posi-



tive proof of this, in attempting to turn the child, for then we feel very powerfully the action of the uterus, and the efforts which it makes to expel its contents. It is not just, however, to consider the action of the womb itself, as the sole agent in parturition; for in the second stage, the abdominal muscles do assist in the expulsion, not only by supporting the uterus, and thus enabling it to contract better, but also directly, by endeavouring to force the uterus, and consequently its contents, down through the pelvis. Two purposes are intended by the uterine action; the first is to open the os uteri, the second to propel the fœtus through it. Whilst, then, the fibres of the uterus itself contract, those of the <sup>os</sup> uteri must dilate, and, in proportion as the fœtus advances through the pelvis, the uterine fibres must shorten themselves. Thus the uterine cavity is gradually diminished, so that the placenta can very easily, by a continuation of the same process, be thrown off; and the uterine vessels having their diameter greatly lessened, hemorrhage is prevented after the separation of the placenta.

Parturition, then, is a muscular action, and we might in one view conceive that it should be most speedy and easy in those who possessed a powerful muscular system, and great vigour. But this is far from being the case, for the process is tedious or speedy, easy or difficult, according to the relation which the power bears to the obstacle to be overcome. Now in many weak and debilitated women, the parts very easily relax and dilate, and a very small power is required to complete the expulsion; whilst we often find, that, those who possess a tense fibre, and great strength of the muscular system, accomplish the dilation of the os uteri, not without much pain, and repeated efforts.

#### SECTION FIFTH.

Women in a state of nature make little preparation for their delivery, and conduct the process of parturition without much ceremony. They retire to the woods, or seclude themselves in a hut or bower, until they bear the child; after which, if the religious custom of their country do not re-

quire their separation for a time, they return to their usual mode of living.

In Europe, we find that the process of parturition is conducted with more care, and is supposed to require greater preparation. Different countries have different customs in this respect. In some, women are delivered upon a chair of a particular construction: in others, seated on the lap of a female friend. Some women use a little bed, on which they rest, until the process be completed; and others are delivered on the bed on which they usually sleep. This last, for many reasons, is the best and most proper practice; but in order to prevent the bed from being spoiled, or wet with the liquor amnii or blood, and also from other motives of comfort, it is usual to make it up in a particular manner. The mattress ought to be placed uppermost, and a dressed skin, or folded blanket, placed on that part of it on which the breech of the woman is to rest. The bed is then to be made up as usual; after which, a sheet folded into a breadth of about three feet, is put across the under fold of the bed-sheet. This is intended to absorb the moisture; and after delivery, if not during labour, that part which is wet is to be drawn completely away, so that a dry portion may be brought under the woman. This arrangement is generally attended to by the nurse, whenever labour begins. When the pains begin, the woman generally dresses in dishabile; but when the process is considerably advanced, it is necessary to undress, and lie in bed. Some at this time put on a half-shift, that is to say, one that does not reach below the waist, so that it is not liable to be wet. Others are satisfied with having the shift pushed up over the pelvis, so as to be kept dry; its place, in either case, is supplied with a petticoat. These, and other circumstances relating to dress and to the quantity of bed-clothes, must be determined by the woman herself, and the season of the year.

It is of consequence that the room be not overheated by fire, or the woman kept too warm with clothes. Heat makes her restless and feverish, adds to the feeling of fatigue, and often, by rendering the pains irregular or ineffective, pro-

tracts the labour. No more people should be in the room than are absolutely necessary. The nurse and one female friend are perfectly sufficient for every good purpose; and a greater number, by their conversation, disturb the patient, or by their imprudence, may diminish her confidence in her own powers, and also in her necessary attendants. The mind, in a state of distress, is easily alarmed; and therefore whispering, and all appearance of concealment, ought to be prohibited in the room.

If the woman be disposed to sleep betwixt the pains, she ought not be disturbed, but allowed to indulge in repose. If she have not this inclination, and be not fatigued, cheerful conversation, upon subjects totally unconnected with her situation, will be very proper.

Women have seldom an inclination for food whilst they are in labour; and, if the process be not long protracted, there is no occasion for it. If, however, the patient have a desire to eat, she may have a little tea or coffee, with dry toast, or a little soup, or some panado; but every thing which is heavy or difficult of digestion must be avoided, lest she be made sick and restless, or have her recovery afterwards interrupted. Even very light food is apt at this time to sour, and cause heartburn.

Stimulants and cordials, such as spiced gruel, cinnamon water, wines, and possets, were at one time very much employed, but now are deservedly abandoned by those who follow the dictates of nature. Given in liberal doses, they are productive of great danger, disposing to fever or inflammation after delivery; and in smaller doses, they disorder the stomach, and often, instead of forwarding, retard the labour. If, however, the woman be weak, or the process tedious, then a small quantity of wine, given prudently, may be of considerable advantage.

Some women wish to keep out of bed as much as possible, in order that labour may be forwarded by walking about; others have the same desire, from feeling easier when they are sitting. In this respect, they may be allowed to please themselves, but they must neither be encouraged nor per-



mitted to walk about so much or so long as to occasion fatigue.

The urine ought to be regularly and frequently evacuated ; and for that purpose, the practitioner should occasionally leave the room. If the woman be costive, or the rectum contain feces, a clyster ought always to be given early, which facilitates the labour. On the other hand, if the bowels be very loose, a few drops of tincture of opium may be given with much advantage.

It is immaterial in what posture the woman place herself during the first stage of labour ; but in the second stage, when delivery is approaching, it is proper that she be placed on her side, and it is usual for her to lie on the left side, as this enables the practitioner to use his right hand. The knees are a little drawn up, and generally at this time kept separate, by means of a small pillow placed between them. Many women wish to have their feet supported, or pressed against by an assistant, and it is customary to give her a towel to grasp in her hand. This is either held by the nurse, or fastened to the bed post. We must, however, be careful that these contrivances do not encourage the woman to make strong efforts to bear down.

When the woman is in bed, it is proper to have a soft warm cloth applied to the external parts, in order to absorb any mucus or water that may be discharged, and this is to be removed when it is wet.

Attempts to dilate the os uteri or the vagina, and the application of unctuous substances, to lubricate the parts, are now very properly abandoned by well instructed practitioners.

The membranes ought generally to be allowed to burst, by the efforts of the uterus alone, for this is the regular course of nature ; and a premature evacuation of the water either disorders the process and retards the labour, or, if it accelerate the labour, it renders it more painful. I cannot, however, go the length of some, who say, that the evacuation of the water is always hurtful ; for there are circumstances in which it may be allowable and beneficial. It is allowable

when the os uteri is fully dilated, and the membranes protruded, perhaps even out of the vagina. In such a case, they would in a few pains at farthest give way; but by rupturing them, we can take precautions to keep the person dry, and more comfortable than she would otherwise have been. Even if the membranes are not considerably protruded, if the os uteri be completely dilated, no injury can arise from rupturing them, for they ought, in the natural course of labour, to give way at this time. But although the practice be not detrimental, yet it does not thence follow that it is always expedient; and it will be a useful rule to adhere to, that the seldomer we interfere in this respect in a natural labour, the more prudent will our conduct be.

Examination ought, in the first stage of labour, to be practised seldom; in the second stage we must have recourse to it more frequently; and, when the pains are becoming stronger and the head advancing, we must not leave the bedside. At this time we should be prepared for the reception of the child. A pair of scissars, with some short pieces of narrow tape, must be laid upon the bed or chair, and a warm cloth or receiver must be at hand, or spread under the clothes, to wrap the child in. As the fæces are generally passed at this time involuntarily, a soft cloth is to be laid on the perinæum; and when the second stage of labour is drawing to a conclusion, the hand is to be placed on this, in order to prevent the rapid delivery of the head, and the consequent laceration of the perinæum. This is a point of very great importance, and which requires to be carefully considered by the practitioner. There are several arguments against this practice: for we should, *a priori*, conceive, that as parturition is a natural process, it ought not in any part to be defective, or to require the regulation of art. Next, we should strengthen this doctrine, by finding, that in the savage state, a lacerated perinæum is rarely discovered, and in all those women who are speedily delivered by themselves, the perinæum is seldom if ever torn. But on the other hand, the fact is ascertained beyond all dispute, that the perinæum is sometimes lacerated, notwithstanding these presumptive proofs a-

against the occurrence of the accident. This being ascertained, it becomes our duty, however rare the case may be, to determine its causes, and prevent its occurrence in every instance; for we cannot exactly say who the unfortunate individuals may be, to whom it is to happen. We may decidedly say, that the perinæum is torn in consequence of distension; but in every delivery, the perinæum must be distended, and in some to a great degree. In proportion to the facility of the distension, and the ease with which the vagina dilates, is the risk of laceration diminished. It has, therefore, become a practical rule, to resist, with the hand placed on the perinæum, the delivery of the head, until the parts be sufficiently relaxed; and this pressure ought to be exerted over the whole tumour, but especially at the fourchette, for although the perinæum has been perforated by the head, which did not pass through the orifice of the vagina, yet usually, the rent begins at the fourchette and proceeds backwards to a greater or less degree. By firmly supporting the perinæum, and, at the same time, exhorting the woman not to force down during a pain, and thus retarding the delivery of the head until we feel the vulva, as well as the perinæum relaxing, we may generally prevent laceration, and therefore this accident will seldom if ever happen in the hands of a prudent practitioner. Still it is possible for the perinæum to be torn under good management. A little bit of it is not unfrequently lacerated, notwithstanding all our precaution; and although, in this slight degree, it is of no consequence, yet we thus see that art cannot always completely prevent the accident. Sometimes the restlessness of the patient almost inevitably prevents the necessary precautions from being used\*; and it may happen, that the frame is so very irritable, that the perinæum unexpectedly lacerates at the time when it is supposed to be in a favourable state. As there must be some point where the resistance must stop, else the labour would be unnecessarily protracted, or perhaps even

\* Dr Denman, a most worthy and experienced practitioner, with a candour which does him great honour, acknowledges, that from this cause the accident occurred in his own practice.



the uterus ruptured, it is possible that such resistance may be made, as generally is sufficient to prevent the accident, but which may not in some particular case, owing to the irritable state of the perinæum, be adequate to the intended purpose; or the power of the uterus may be so strong as to expel the head, in spite of every allowable resistance, and in some of these cases it is possible for the perinæum to be torn.

It is not sufficient that the practitioner support the perinæum, until the head is going to be expelled; he must continue to do so whilst it is passing out, for there is then a great strain on the part, as the forehead is passing over the perinæum, and even the face moving along it, may produce injury. After the head is delivered, it is still necessary to place the hand under the chin, and on the perinæum, for the arm of the child comes next to press against this part, and may either tear it by pressure, or by coming out with a jerk. Farther, to prevent injury and avoid pain, the body of the child should be allowed to pass out in a direction corresponding to the outlet of the pelvis, that is to say, moving a little forwards. But there is no occasion that the child should be carried forward betwixt the thighs, for, in a natural labour, the back of the child is directed to the thighs; it can easily bend, and will naturally so incline itself in the delivery, as to take the proper direction. The last advice to be given respecting this stage of labour is, that as we retard rather than encourage the expulsion of the head, so we are not to accelerate the delivery of the body. Women in a state of pain call for relief, and expect that the midwife is to assist the delivery of the child; but no entreaties ought to make us hasten the expulsion of the head, and after that event, there is little inducement to accelerate the labour. Sometimes, in a few seconds, the child is expelled, but there may be a cessation of pain for some minutes. In the first case, we take care that the body is not propelled rapidly, and with a jerk: In the second, we attend to the head, examining that the membranes do not cover the mouth, but that the child be enabled to breathe, should the circulation in the cord be obstructed. There is no danger in delay,

and rashly pulling away the child is apt to produce flooding and other dangerous accidents. Should there, however, be a considerable interval betwixt the expulsion of the head, and the accession of new pains, we may press gently on the belly, or pull the child slightly, so as to excite the uterus to contract. Or, should the woman have several pains without expelling the body of the child, it may be allowable gently to insinuate the finger, and bring down the shoulder; but even this assistance is rarely required, and on no account ought we to attempt the delivery by pulling the head. Sometimes a delay is produced by the cord being twisted round the neck; and in this case, all we have to do, is to slip it off over the head.

The child being born, a ligature is to be applied on the cord very near the navel, and another about two inches nearer the placenta. It is then to be divided betwixt them, and the child removed. The hand is next to be placed on the belly, to ascertain that there be not a second child; and the finger may, for the same purpose, be slid gently along the cord to the os uteri. The hand of an assistant should be applied on the abdomen, and gently pressed on the uterus, which may excite it to action, and prevent torpor. If the placenta be not expelled soon, the uterine region may be rubbed with the hand to excite the contraction of the womb. Immediately after the expulsion of the child, there is often a copious evacuation of water, which is sometimes mistaken by the woman for a discharge of blood. But hemorrhage never takes place so instantaneously, in such quantity. It is generally a minute or two, sometimes much longer, before flooding come on; against the occurrence of this, we are to be on our guard.

The woman, after the delivery of the child, feels quite well, and expresses, in the strongest language, the transition from suffering to tranquillity. But in a short time, generally within half an hour, one or two trifling pains are felt, and the placenta is expelled, which completes the last stage of parturition; and when the process goes on regularly, no-

thing is required in this stage, except watchfulness, least hemorrhage supervene.

But it sometimes happens, that the placenta does not come away so early or so readily as we expect. It may be retained for many hours, or even for some days. This retention can be caused by preternatural adhesion of the placenta, or by the uterus contracting spasmodically round the placenta, forming a kind of cyst, in which it is contained; or the uterus may not contract on the placenta so strongly as to expel it. Some, from a confidence in the powers of nature, have inculcated as a rule of conduct, that unless flooding take place, the placenta ought not to be extracted. Others have, with equal zeal, advised it to be brought away immediately after the birth of the child. The safest practice seems to lie betwixt the two extremes. To leave the expulsion of the placenta altogether to nature, is a step attended with great danger; for as long as it is retained, we may be sure that the uterus has not contracted strongly and regularly. If then, in these circumstances, the placenta should be partially or completely detached, hemorrhage is very likely to occur. If it still adhere to the uterus, the risk of hemorrhage certainly is diminished, for those vessels alone, which opened on the decidua, can be exposed; but we have no security that this adhesion shall remain universal for any given time. As long, then, as the placenta is retained, the woman is never free from the risk of flooding. In many cases, she has died from this cause before the placenta was expelled; or if, after a long delay, the placenta has come away, its exclusion has sometimes been followed by fatal hemorrhage.\* But this, although a dreadful accident, is not the only one arising from retention of the whole or part of the placenta. For great debility, constant retching, and fever, are often produced by this cause, and may ultimately carry off the patient. It is therefore not without great reason, that women are anxious for the expulsion of the pla-

\* Mr Whyte, has, in his Treatise on the Management of Pregnant and lying in Women, p. 307, related several cases where the practice of leaving the placenta to be expelled by nature alone, was productive of fatal hemorrhage: and in one instance, this event took place, although the placenta was at last expelled.



centa; and this prejudice may have a good effect in operating against the conceits of speculative men, who suppose that nature is, in every instance, adequate to the accomplishment of her own purposes.

On the other hand, daily experience must convince every one, that there is no occasion for extracting the placenta immediately after the birth of the child, for it is usually expelled, with perfect safety, within forty minutes after the child is delivered. Nay, we find that the speedy extraction of the placenta is directly hurtful; both as it is painful, and also as it is sometimes followed by uterine hemorrhage, or, if rashly performed, by inversion of the womb. The practice then, I think, may be comprised in two directions: First, that we ought never to leave the bed-room, until the placenta be expelled; and, secondly, that if it be not excluded in an hour after delivery, we ought to extract it. This point being adjusted, it is next to be inquired, how the retention is to be prevented, and, if not prevented, how the placenta is to be extracted. With regard to the first question, it may be answered, that the placenta will be less apt to be retained, if the expulsion of the child be conducted slowly, and the uterus made to contract fully upon it. As to the mode of extracting the placenta, we can be at no loss, if we recollect that the expulsion is accomplished by the contraction of the uterus. Our object, then, is to excite this when the placenta is retained, in consequence of the womb not acting strongly. The hand is to be slid slowly and cautiously into the uterus, which is often sufficient to make it contract; but if it do not, the hand is to be moved a little, or pressed gently on the placenta, at the same time that we pull very slightly by the cord, or lay hold of the detached placenta with our hand, and with caution extract it slowly. This requires no exertion, for the uterus is pressing it down, and, if any force be used, we do harm. Attempts to bring away the placenta, by pulling strongly at the cord, whether the hand be introduced into the uterus or not, are always improper. If persisted in, they generally end, either in the laceration of the cord, or the inversion of the uterus.

There are two circumstances, however, under which the placenta may be retained, which require some modification of the practice. The first is, when the placenta is retained by spasm. In this case, when the hand is conducted along the cord through the os uteri, the placenta is not perceived, but it is led by the cord to a stricture, like a second, but contracted os uteri, beyond which the placenta is lodged. This contraction must be overcome before the placenta can be brought away, which may be accomplished by gradual and continued attempts to introduce one, two, or more fingers through it; and these, if cautiously made, are perfectly safe. It will, however, be observed, that the uterus at short intervals contracts, which is accompanied with pain; but this contraction is confined to the stricture alone, the cavity of the womb not being lessened by it, and during this state all attempts to dilate the aperture are hurtful. We must be satisfied with keeping the fingers in their place, to preserve the ground we have gained. Opiates have been proposed to remove this spasm, and render the introduction of the hand unnecessary; they seldom, however, succeed alone, but given in a full dose may make the manual attempt more easy. Sometimes the sudden application of a cloth, dipped in cold water, to the belly, has the same effect. The second circumstance to which I alluded is, adhesion of the placenta, which usually is only partial. This may occur with or without a change of structure, but in general the structure is more or less altered, the adhering part being denser than usual, and sometimes almost like cartilage. The separation of the adhering portion should not be attempted hastily, nor by insinuating the finger between it and the uterine surface. It is better to press on the surface of the placenta, so as thus to excite the uterine fibres to contract more briskly at the spot; or by gently rubbing, or, as it were, pinching up the placenta between the fingers and thumb, it may be separated. If, however, the adhesion of the part of the placenta be very intimate, we must not, in order to destroy it, scrape and irritate the surface of the uterus, but ought rather to remove all that does not adhere intimately, leaving

the rest to be separated by nature<sup>1</sup>. But in taking this step, we are not to proceed with impatience, nor to attempt to bring away the non-adhering portion, until a considerable time has elapsed, and cautious efforts have been made to remove the entire placenta; thus satisfying ourselves of the existence of an obstinate and intimate union. Cases, where this conduct is necessary, are very rare, and when they do occur, there is usually an induration of the adhering part. It is generally thrown off in a putrid state in forty-eight hours. Sometimes the placenta adheres when it is unusually tender and soft, and then we must, with peculiar care, avoid hasty efforts, by which the placenta would be lacerated, and part left behind, which would be hurtful afterwards; whereas by a little more patience, and gentle pressure on the surface of the placenta, the uterus might have been excited to throw the whole off.

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### CHAP. III.

#### *Of Premature Labour.*

WHEN a woman bears a child in any of the three last months of pregnancy, she is said to have a premature labour; and this process forms a medium between abortion and natural labour.

In some cases, the uterus is fully developed before the usual term of gestation, and then contraction commences; but, in a great majority of instances, premature labour proceeds from accidental causes, exciting the expulsive action of the uterus, before the cervix and os uteri have gone through their regular changes. The cervix must, therefore, be expanded by muscular action, before the os uteri can be properly dilated; and this preparatory stage is generally marked by irregular pains, and not unfrequently by a feverish state, preceded by shivering. A feeling of slackness about the belly, with different anomalous sensations, often accompany this stage of premature labour. When the cervix is expanded, then the os uteri begins to dilate, and this part of



the process is often more tedious than the same period of natural labour, and generally as painful. It is also frequently attended with a bearing-down sensation. The second stage of labour is usually expeditious, owing to the small size of the child. The decidua being thicker than at the full time, the protrusion of the membranes is attended with more sanguineous discharge; and if the woman move much, or exert herself, considerable hemorrhage may take place. The third stage is likewise slow, for the placenta is not soon thrown off. In the last place, spasmodic contraction of the uterus is more apt to take place in all the stages of premature than of natural labour. A variety of causes may excite the action of the uterus prematurely, such as distention from too much water; or the death of the child, which is indicated by shivering, subsidence of the breasts, cessation of motion, and of the symptoms of pregnancy; or the artificial evacuation of the liquor amnii; or violent muscular exertion; or passions of the mind; or acute diseases; or rigidity of the uterine fibres. Certain general conditions of the system render the operation of these causes more easy, such as plethora, debility, and great irritability.

A tendency to premature labour is to be prevented by the means pointed out when treating of abortion. I have only to add, that when the abdomen is tense and hard, or painful, indicating a rigidity of the uterine fibres, or of the abdominal muscles, tepid fomentations, gentle laxatives, and repeated small bleedings, are useful.

When a woman is threatened with premature labour, we ought, unless there be very decided marks of the death of the child, to endeavour to check the process, which is done by exhibiting an opiate, keeping the patient cool and tranquil, and removing any irritation which may exist. If she be plethoric, or the pulse be throbbing, blood is to be detracted.

When labour is established, it is to be conducted much in the same way with parturition at the full time; but the following observations will not be improper. The patient must

avoid much motion, lest hemorrhage be excited. Frequent examination and every irritation are hurtful, by retarding the process, and tending to produce spasmodic contraction. If this contraction take place, marked by paroxysms of pain referred to the belly or pubis, little or no effect being produced on the os uteri, a full dose of tincture of opium should be given, after the administration of a clyster. Severe pains, with premature efforts to bear down, and a rigid state of the os uteri, require venesection, and afterwards an opiate. The delivery of the child is to be retarded, rather than accelerated in the last stage, that the uterus may contract on the placenta. This is farther assisted, by rubbing gently the uterine region after delivery. If the placenta be long retained, or hemorrhage come on, the hand is to be gently introduced into the uterus, and pressed on the placenta, to excite the fibres to throw it off. We should not rashly attempt to remove it, for we are apt to tear it; neither are we to pull the cord, for it is easily broken. In those cases where premature labour is connected with redundancy of liquor amnii, I think it useful to introduce the hand immediately on the delivery of the child, for I have observed, that the placenta is apt to be retained by irregular contraction. We do not instantly extract the placenta, but it is desirable to get the hand in contact with it before the circular fibres contract.

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#### CHAP. IV.

##### *Of Preternatural Labour.*

Various signs have been enumerated, by which it was supposed, that malposition of the child might be discovered antecedent to labour. An unusual shape of the abdomen; some peculiar feeling, of which the mother is conscious, and which she has not felt in any former pregnancy; greater pain or numbness in one leg than in the other; a sensation of the child rising suddenly towards the stomach; have all been mentioned as indicating this, but are all, even when

taken collectively, uncertain tokens. We cannot determine the presentation, until labour has begun. In a great majority of instances, the head, during the end of gestation, may be felt resting on the cervix uteri, but, in repeated instances, I have not been able to distinguish it in a pregnancy which ended in natural labour. Sometimes, in consequence of a fall, or other causes, the head seems to recede, but afterwards returns to its proper position. When labour begins, we may generally distinguish the head by its proper character; but, if it lie high, and especially if the pelvis be deformed, we may not find it always easy to ascertain the presentation at a very early period. In such cases, it is of great consequence to preserve the membranes entire. When the head does not present, the presentation is generally more distant, and longer of being distinctly ascertained\*, the lower part of the uterus is more conical, and the tumor formed by the cranium cannot be felt through the membranes or cervix uteri: when the finger touches the part through the membranes, it very easily recedes, or seems to rise up. If the child lie more or less across the uterus, the os uteri is generally long of being fully dilated, the membranes protrude like a gut, and sometimes, during the pains, the woman complains of a remarkable pushing against the sides. The pains are severe, but in cross presentations, she is sensible that they are not advancing the labour.

It is a fact well ascertained, that although the head have been felt distinctly in the commencement of labour, yet, when the membranes break, it may be exchanged for the shoulder†, or some other part. On this account, as well as for other reasons, it is always proper to examine immediately after the membranes have given way.

\* When the presentation is long of being felt, we have been advised to examine the woman in a kneeling posture, or even to introduce the hand into the vagina, and rupture the membranes. The last advice is sometimes useful, as it enables us, if the presentation require it, to turn the child at a time when it can be easily done. But this is not to be hastily practised, nor adopted till the os uteri be well dilated.

† I have been informed of a case, where the shoulder was exchanged for the head, and Joerg seems to have met with the same circumstance. Hist. Partus, p. 90.



## ORDER FIRST.

The breech is distinguished by its size and fleshy feel, by the tuberosity of the ischia, the shape of the ilium, the sulcus between the thighs, the parts of generation, and by the discharge of meconium, which very often takes place in the progress of labour\*. After the breech has descended some way into the pelvis, the integuments may become tense or swelled, so as to make it resemble the head. Before the membranes burst, the presentation is very mobile, and bounds up readily from the finger.

Many have advised, that when the breech presented, the feet should be brought down first; but the established practice now is, when the pelvis is well formed, and other circumstances do not require speedy delivery, to allow the breech to be expelled without any interference, until it has passed the external parts.

The breech, and consequently the body of the child, may vary in its position with regard to the mother; but there are chiefly two situations requiring our attention, because the rest are ultimately reduced to these. First, where the thighs of the child are directed to the sacro-iliac junction of the pelvis; and secondly, where they are directed to the acetabulum. In either of these cases, delivery goes on with equal ease, until the head comes to pass. Then, if the thighs have been directed to the fore part of the pelvis, the face will also be turned toward the pubis, and cannot clear its arch so easily as the vertex.

When the thighs are directed to the back part of the pelvis, we find that the process of delivery is as follows: The breech generally descends obliquely, one tuberosity being lower than the other. The lowest one follows the same turns as the vertex does in natural labour, and observes the same relation to the axis of the brim and outlet of the pelvis. The breech is expelled with one side to the symphysis of the pubis, and the other to the coccyx; and after the presenting tu-

\* A discharge of liquor amnii, apparently coloured with meconium is no proof that the breech presents, neither is it a sign that the child is dead.

berosity protrudes under the arch of the pubis, the other clears the perinæum, like the face, in natural labour. Whilst the breech is protruding, it gradually turns a little round, so that the shoulders of the child come to pass the brim diagonally, the diameter from the acetabulum to the sacro-iliac junction being the greatest. The breech being delivered, a continuance of the pains pushes it gradually away, in the direction of the axis of the outlet, until the legs come so low as to clear the vagina. When this takes place, the head is generally passing the brim obliquely, the face being turned toward the sacro-iliac junction; and most frequently the arms pass along with it, being laid over the ears. They then slip down into the vagina, by the action of the uterus, and the head alone enters the cavity of the pelvis. The face turns into the hollow of the sacrum, and the chin tends toward the breast of the child. Then it clears the perinæum, which slips over the face, and the vertex comes last of all from under the pubis. If, however, the chin be folded down on the breast before the head has descended into the pelvis, then, from the unfavourable way in which it enters the brim, there may be some difficulty to the passage, for it in some respects resembles a presentation of the face. The hand should be introduced, and the face pressed up. In one case, Dr Smellie found so much difficulty, that he applied the crotchet on the clavicle.

Now the management of this labour is very simple. Whilst the breech is coming forth, the perinæum is to be supported, and nothing more is to be done till the knees are so low as to be on a line with the fourchette. If they do not naturally bend, and the feet slip out, the finger of one hand is to be employed to bend the leg gently, and bring down the foot; the knee, in this process, pressing obliquely on the abdomen of the child. But whether the legs be expelled naturally, or be brought down, we must carefully protect the perinæum, lest it should be torn by a sudden stroke of the leg in passing. Next, the cord is to be pulled gently down a little, to make the circulation more free. Thirdly, we attend to the arms; if these do not descend by the natu-

ral efforts, we introduce a finger, and gently bring down first one, and then the other, using no force, lest the bone should break. The perinæum is also to be guarded, to prevent a slap of the arm from injuring it. Fourthly, if the head do not directly turn down, the finger is to be carried up, and placed upon the chin or in the mouth, in order gently to depress it toward the breast, and this is generally sufficient. To guard the perinæum, the hand must be applied on it, and the body of the child moved near the thighs of the mother, that the vertex may more readily rise behind the pubis, whilst the face is passing. If the body be, on the contrary, removed farther from the mother, and nearer the operator, the head can neither pass so easily into the pelvis, nor out from the vagina. In a natural labour, after the head is expelled, the whole body should be allowed to be slowly born by the efforts of the womb alone. But in breech cases, should the process, after the breech is expelled, be slow, the delivery of the body and head must by the means I have related, be accelerated, lest the umbilical cord suffer fatal compression. The first symptom of danger is a convulsive jerk of the body, and, if the head be not speedily brought down, the child will be lost. Should delay inevitably arise, we must try to bring the cord to the widest part of the pelvis. But even although all pressure could be removed, the child cannot live long, if it be not delivered, as the function of the placenta is soon destroyed, that organ being often entirely detached from the womb, following the head whenever it is born.

When the thighs, in breech cases, are directed to the pubis or acetabulum, then the face cannot turn in to the hollow of the sacrum. It rests for some time on the pubis, and it comes out with difficulty upon the arch; for in breech and footling cases, the face is generally born before the vertex. In order to prevent this difficulty, it will, as soon as the breech is expelled and the feet are delivered, be proper to grasp the breech, and slowly endeavour to turn the body round; but, should this not succeed, or not have been attempted till the shoulders have come down, and the head is a-



bout to pass the brim, the practice is dangerous, and the neck may be materially injured. It is, in this case, better to introduce a finger, and press with it on the head itself, endeavouring thus to turn the chin, from the acetabulum to the sacro-iliac junction of the same side. If the position be not rectified, then we assist the descent by depressing the chin, and gently bringing it under the pubis; and this may be facilitated by pressing the vertex upward and backward, making it turn up on the curve of the sacrum, to favour the descent of the face. We must be careful of the perinæum.

When the pelvis is contracted or deformed, it will be prudent, at an early stage of the labour, to bring down the feet. But if this have been neglected, then should the difficulty of delivery, or the length of time to which the labour is protracted, require it, we must insinuate a blunt hook, or a soft ribband, over one of the groins, and thus extract the breech; or the forceps may with much advantage be applied. When the resistance is slight, the insinuation of the fingers over the groin, may sometimes enable us to use such extracting force, as at least excites the uterus more briskly to expel. Should the head not easily follow the body, we must not attempt to extract it by pulling forcibly at the shoulders, as we may thus tear the neck, and leave the head in utero\*. The cord is, first of all, to be freed as much as possible from compression; then we gently depress the shoulders, in the direction of the axis of the brim, at the same time that we with a finger act upon the chin. Should this not succeed, we must apply the lever over the head, and depress in the proper direction. If this fail, the only resource is to open the cranium above or behind the ear, and fix a hook in the aperture; but this is not to be done until we have fully tried other means, and by that time the child will be dead.

When the breech presents, and parturition is tedious, the parts of generation are often swelled and livid. When the

\* La Motte, Chapman, Smellie, and Perfect, give examples of the head being left in utero without the body, and the body without the head. There are chiefly two sources of danger, the first and most immediate, is uterine hemorrhage; the second, is the consequence of putrefaction, which produces sickness, nausea, fever, and great debility. The head may be extracted, by fixing a finger in the mouth, or by the crotchet, with or without perforation.

parts are merely turgid a little, and purple from congestion of venous blood, nothing is necessary to be done. But when inflammation takes place, it is more troublesome, for being of the low kind, it is apt to end in gangrene. Fomentations are useful, but often spirituous applications succeed best.

#### ORDER SECOND.

Presentation of the feet is known, by there being no rounded tumor formed by the lower part of the uterus. The membranes also protrude in a more elongated form than when the head or breech present. The presenting part, when touched during the remission of the pain, is felt to be small, and affords no resistance to the finger. When the membranes break, we may discover the shape of the toes and heel, and the articulation at the ankle. Sometimes both the feet and the breech present. Two circumstances contribute to an easy delivery: first, that the toes be turned toward the sacro-iliac junction of the mother; and secondly, that both feet come down together. The best practice is, to avoid rupturing the membranes till the os uteri be sufficiently dilated; then we grasp both feet, and bring them into the vagina; or, if both present together at the os uteri, we may allow them to come down unassisted. In either case, we do not accelerate the delivery till the cord is in a situation to suffer from pressure, that is, till the knees are fully protruded, and the thick part of the thighs, near the breech, can be felt; then, if the face be towards the belly of the mother, we grasp the thighs, and gently turn the body round. The management is the same as in breech cases. There is little danger of the feet of two different children being brought down together, as twins are included in separate membranes. But as the case is possible, it is proper to attend that the feet be right and left.

Sometimes a knee and foot, or the knees alone, present; and as they form a larger tumor than the feet, they may at first be taken for the breech or the head. Generally only one knee presents, and it lies obliquely, with its side on the os uteri. It is known by its shape, and the flexure of the

joint. Some advise that the case should be left altogether to nature, but it is often advantageous to bring down the feet.

#### ORDER THIRD.

When the shoulder or arm presents, the case has the general character of preternatural presentations. The round tumor, formed by the head in natural labour, is absent, whilst we can ascertain the shape and connection of the arm and shoulder. A shoulder presentation can only be confounded with that of the breech. But in the former case, the shape of the scapula, the ribs, the sharpness of the shoulder joint, and the direction of the humerus, together with our often feeling in our examination either the hand or neck, will be distinguishing marks. In the latter, the rounder shape and greater firmness of the ischium, the size of the thigh, its direction upward, and its lying in contact with the soft belly, the spine of the ilium, the parts of generation, the size of the tuberosity of the ischium, and the general shape of the back parts of the pelvis, contribute with certainty to ascertain the nature of the case.

The hand and arm may present under different circumstances. The original presentation may have been that of the shoulder, but the arm may have, in the course of the labour been expelled; or the hand may rest on the os uteri, before the membranes have broken; or the fore arm may, for a length of time, lie across the os uteri, the hand not being protruded for some hours. Sometimes both hands are felt at the os uteri, and even both arms may be expelled into the vagina; but in most cases this does not happen, unless an improper conduct be pursued. In some rare instances, the hands of twins have been found presenting together, both sets of membranes having given way: it is more common to find both the hands and feet of the same child presenting; and this, next to the presentation of the feet alone, is the easiest case to manage\*. It is not uncommon, in this case,

\* If the uterus be firmly contracted, the liquor amnii having been all evacuated, it may sometimes be necessary to carry the hand up to the knees, and change the situation.



to find the cord presenting at the same time, and then, by delay, the child may be lost.

In most cases where the superior extremities present, the feet of the child are found in the fore part of the uterus, toward the navel of the mother. But their situation may be known, by examining the presentation. If we feel the shoulder, we know, that if the scapula be felt toward the sacrum, the feet will be found toward the belly. If the arm be protruded into the vagina, the palm of the hand is found in pronation, directed toward the side where the feet lie. It is easy to know which hand presents. If we examine with the right hand, we shall find, that if the palm of the child's hand be taken into ours in a state of pronation, the thumb of the right hand, or the little finger of the left hand, will correspond to our thumb.

In these preternatural presentations, the ancients were acquainted with the practice of turning, and delivering the child by the feet. But their remarks on this subject formed no general rule of conduct; on the contrary, practitioners were almost invariably in the habit of endeavouring to remove the presentation, and to bring the head to the os uteri. Paré was among the first who advised turning as a general practice; but even his pupil Guillemeau disregarded the rule, and left it to Mauriceau to enforce it, both by reasoning and practice\*.

We should be careful not to rupture the membranes prematurely; and more effectually to preserve them entire, we must prevent exertion, or much motion on the part of the mother. As soon as the os uteri is soft, and easily dilatable, the hand should be introduced slowly into the vagina, the os uteri gently dilated, and the membranes ruptured. The hand is then to be immediately carried into the uterus, and upwards until the feet are found. Both feet are to be grasp-

\* Mauriceau justly observes, that although, after much fatigue, the head can be brought to the os uteri, the woman may not have strength to finish the delivery.—In a case mentioned by Dr Smellie, the patient died of flooding.—Joerg still admits the propriety of bringing the head, when it is nearer than the feet, to the os uteri, or the fetus is so placed, that the feet cannot without difficulty and danger be brought down.

ed betwixt our fingers, and brought down into the vagina, taking care that the toes are turned to the back of the mother. The remaining steps have been already described. This operation is not very painful to the mother; it is easily accomplished by the accoucheur, and it is not more hazardous to the child than an original presentation of the feet. But it is necessary in order to render this assertion correct, that the operation be undertaken before the liquor amnii be evacuated; and it is of importance to fix upon a proper time. We are not to attempt the introduction of the hand whilst the os uteri is hard and undilated; this is an axiom in practice; on the other hand, we are not to delay until the os uteri be dilated so much, as to be apparently sufficient for the passage of a bulky body. In the cases now under consideration, the os uteri does not dilate so regularly, and to so great a degree, before the membranes break, as when the head presents. If we wait in this expectation, the membranes will give way before we are aware. If the os uteri be dilated to the size of half a crown, thin and lax, the delivery ought not to be delayed, for every pain endangers the rupture of the membranes. If they do give way, we are immediately to introduce the hand, and will still find the operation easy, for the whole of the water is not discharged at once, nor does the uterus immediately embrace the child closely. If the liquor amnii have been discharged in considerable quantity previous to labour, or if the membranes have burst at the commencement of it, when the os uteri is firm and small, we must by a recumbent posture, try still to preserve a portion of the waters, till the orifice will permit delivery. The introduction of the hand into the vagina and os uteri may be rendered easier, and less painful, by previously dipping it in oil or lintseed tea, or any other lubricating substance.

But if the water has been long evacuated, then the fibres of the uterus contract strongly on the child, the presentation is forced firmly down, and the whole body is compressed so much, that the circulation in the cord frequently is impeded, and, if the labour be protracted, the child may be

killed. This is a very troublesome case, and requires great caution. If the pains be frequent, and the contraction strong, then all attempts to introduce the hand, and turn the child, must not only produce great agony, but, if obstinately persisted in, may tear the uterus from the vagina, or lacerate its cervix or body. After a delay of some hours, however, the uterus may be less violent in its action, or by medical aid, the pains may be suspended. Copious blood-letting, certainly, has a power in many cases of rendering turning easy, but it impairs the strength, and often retards the recovery. If the patient be restless and feverish, it may, to a certain extent, be necessary and proper; but if not, we shall generally succeed, by giving a powerful dose of tincture of opium, not less than sixty or eighty drops. Previous to this, the bladder is to be emptied, lest it should be ruptured during the operation; and, if necessary, a clyster is to be administered. The patient is then to be left, if possible, to rest. Sometimes in half an hour, but almost always within two hours after the anodyne has been taken, the pains become so far suspended, as to render the operation safe, and perhaps easy. Our first object is, to get the hand into the uterus; and for this purpose, we must raise up the shoulder a little, working the fingers past it, by slow, cautious, but steady efforts. The cervix often contracts spasmodically round the presentation, and is the chief obstacle to the delivery, but the opiate generally allays this\*. Sometimes our efforts renew the pains, which, although they may not prevent the operation, make it more painful, and cramp and benumb the hand. Having passed the hand beyond the cervix, we carry it on betwixt the body of the child and the surface of the uterus, which is felt hard and smooth, from the tonic or permanent action of the fibres, until we reach the feet, both of which, if possible, we seize and bring down; but if we cannot easily find both, one is to be brought down into the vagina, and retained there. The child will be born, with

\* The spasm may yield rather suddenly to the hand, as if rupture of the fibres had taken place. I was informed of one case of this kind, but the word was entire, and no bad symptoms came on.



the other folded up on the belly. In bringing down the feet, as well as in carrying up the hand, we must not act during a pain, but should keep the hand flat on the child; a contrary practice is very apt to lacerate the uterus. Before introducing the hand, we must ascertain, by examining the presentation, which way the feet lie, that we may proceed directly to the proper place. We must also consider, whether we shall succeed best with the right or the left hand. If the right shoulder or arm present, some have made it a rule to deliver with the left hand, others with the right; but much must depend on the dexterity of the operator, and the position of the woman. The most common position is the same as in natural labour. Sometimes we may find it useful to make the woman lie forward on the side of the bed, with her feet on the ground, and to place ourselves behind her.

When the hand and arm have been protruded, and the shoulder forced down in the vagina, it has been the practice with many, before attempting to turn, to return the arm again within the uterus; and when this was impracticable, it has been torn or cut off, especially if the child was supposed to be dead. Others advise, that we should not attempt to reduce the arm; nay, even that we should, in difficult cases, facilitate the operation, by bringing down the other arm, in order to change, to a certain degree, the position of the child. So far from it being necessary to replace the arm, we shall sometimes find advantage from taking hold of it with one hand, whilst we introduce the other along it; as the parts are thus a little stretched, and it serves as a director by which we slip into the uterus.

By the means pointed out, and by a steady, patient conduct, we may, in almost every instance, succeed in delivering the child. But it must be acknowledged, that in some cases, from neglect or mismanagement, the woman is brought into great danger, or may even be allowed to die undelivered. This catastrophe proceeds sometimes from mere exhaustion, or from inflammation, but oftener, I apprehend, from rupture of the uterus; or in a neglected case, so much irritation

may be given to the system, as well as to the parts concerned in parturition, that although the delivery be easily accomplished, the woman does not recover, but dies, either from pulmonic or abdominal inflammation, or fever, or flooding. Moreover, such tedious cases generally end unfavourably for the child.

When turning has not been practicable, if the child was supposed to be alive, the os uteri has been cut, or the cæsarian operation has been proposed and practised\*. If dead, it has been extracted, by pulling down the breech with a crotchet†; and sometimes, in order to assist delivery, the body has been mutilated‡, or the head opened with the perforator.

When the child has been small or premature, it has happened that the arm and shoulder have been forced out of the vagina, and then, by pulling the arm, the delivery has been accomplished||. In a greater number of instances, a spontaneous turning of the child has taken place, and the breech has been expelled first. The action of the uterus is exerted in the direction of its long axis, and therefore tends to push its contents through the os uteri. The child forms an ellipse; and either in natural labour, or presentation of the breech, the long axis of the ellipse corresponds to the long axis of the uterus. But in a shoulder presentation, the axis of the ellipse lies obliquely with regard to that of the uterus, or to the direction of the force; and therefore the continued action of the uterus may tend, by operating on the side of the ellipse, to depress the upper end, and in the same proportion elevate the shoulder, the child moving like the beam of a pair of scales. Dr J. Hamilton justly observes, that

\* Vide Memoir by M. Baudelocque, in *Recueil Period.* Tome V. table 1. cases 5 and 15.

† Peu, in one case where both arms were protruded, applied a fillet over the breech to bring it down. *Pratique* p. 412.—Smellie, in 1722 brought down the breech with the crotchet. Col. 35. case 3.—Giffard did the same in 1725, Case 3.

‡ Vide *Perfect*, Vol. I. p. 351.—Dr J. Hamilton's Cases, p. 104. He found it necessary to separate three of the vertebrae.—Dr Clarke twisted off the arm, and perforated the thorax freely. At the end of 36 hours the fœtus was expelled double. *Med. and Phys. Jour.* Vol. VII. p. 394.

|| Giffard, case 211; and Baudelocque l'Art, §. 1530, in a note.—In Mr. Gardiner's case, the head followed the shoulders. *Med. Comment.* V. 307.

the evolution can only take place when the action of the uterus cannot be exerted on the presenting part, or where that part is so shaped that it cannot be wedged in the pelvis. This occurrence was first of all noticed, I believe, by Schoenheider\* ; but Dr Denman † was the first who, in this country, called the attention of practitioners to it. He collected no less than thirty cases, but in these only one child was born alive. It does not appear that the child being large, is an obstacle to the delivery‡. A knowledge of this fact does not exonerate us from making attempts to turn ; for although a considerable number of cases are recorded where it has taken place, yet these are few in proportion to the number of presentations of the shoulder. In this city, which contains not less than 90,000 inhabitants, I cannot learn that more than one case of spontaneous evolution has taken place, though some women have either died undelivered, or have not been delivered until it was too late to save them.

Sometimes the arm presents along with the head, and this can only render delivery tedious or difficult, by encroaching on the dimensions of the pelvis. This case does not require turning ; but if we can, we should return the arm beyond the head ; if we cannot, we may succeed in bringing it to a place where it will not interfere much with the passage of the head. Sometimes the head is placed pretty high, being retained by a spasmodic contraction of a band of fibres round it, and the arm is the only presentation which can be felt, until the hand be introduced. Opiates, in this case, may be of service. We must never attempt by force to destroy the stricture, in order either to return the arm or bring down the head.

Occasionally both a hand and the feet have been found presenting with the head, or the feet and head present. In such cases, we can, if necessary, bring down the feet altogether, and this is in general proper.

\* Acta. Havn. Tom. II. art. xxiii.

† Lond. Med. Jour. Vol. V. p. 64.—See also case by Mr. Outnwait, in New Lond. Med. Jour. Vol. II. p. 172—Mr Simmons Med. Facts and Obs. Vol. I. p. 76—Perfect's cases, II. 367—Med. and Phys. Journ. Vol. III. p. 5.

‡ Mr. Hey's case, in Lond. Med. Jour. Vol. V. p. 305.



Besides these presentations, we may meet with the back part of the neck, and the upper part of the shoulder; or the nape of the neck alone; or the throat. These, which are very rare, require turning. They are recognised by their relation to the head and shoulders.

#### ORDER FOURTH.

The hips, back, belly, breast, or sides, may, though very rarely, present, the child lying more or less transversely. The hip is sometimes taken for the head\*, but is to be distinguished by the shape and relations of the ilium. In all the other cases, the presentation remains long high; but when the finger can reach it, the precise part may be ascertained, by one who is accustomed to feel the body of a child. If the child lie transversely, it may remain long in the same position, and the woman may die if it be not turned. But if, as is more frequently the case, it be placed more or less obliquely, then, if the pains continue effective and regular, either the breech or the shoulder will be brought to the os uteri, according as the original position favoured the descent of one or other end of the ellipse formed by the child. In these presentations, the hand should be introduced, to find the feet, by which the child is to be delivered. But, this rule is not absolute with regard to the presentation of the hip, which only renders labour tedious.

#### ORDER FIFTH.

The child may present the head, and yet it may be improperly situated, and give rise to painful and tedious labour.

1st, The forehead, instead of the vertex, may be turned to the acetabulum. In this case, the presentation is felt in the first stage high up, smooth and flatter than the vertex. In a little longer, we discover the anterior fontanelle, and the situation of the sutures. By degrees, the head enters the cavity of the pelvis, the vertex being turned into the hollow

\* La Motte was of opinion, that no part resembled the head more than the hip. Vide obs. 283 and 284.

of the sacrum ; and by a continuance of the pains, the forehead either turns up within the pubis, and the vertex passes out over the perinæum ; or the face gradually descends, and the chin clears the arch of the pubis, the vertex turning up within the perinæum toward the sacrum, till the face is born. The first is the usual process in this presentation ; all the steps of the labour are tedious, and often, for a considerable period, the pains seem to produce no effect whatever. In the last stage, the perinæum is considerably distended, and it requires care and patience to prevent laceration. This presentation is difficult to be ascertained at an early stage, before the membranes burst ; and sometimes the duration of the labour is attributed to weakness of the uterine action, and not to the position of the head. If it be discovered early, it is certainly proper to rupture the membranes, and turn the vertex round ; a proceeding which is easily accomplished, and which prevents much pain and fretfulness. If this opportunity be lost, we may still give assistance. Dr Clarke says, that in thirteen out of fourteen cases, he succeeded in turning round the vertex, by introducing either one or two fingers between the side of the head near the coronal suture, and the symphysis of the pubis, and pressing steadily, during a pain, against the parietal bone. Of the advantage of this practice, I can speak from my own observation ; and I have, even when the head had descended so low as to have the nose on a line with the arch of the pubis, succeeded in turning the face round to the hollow of the sacrum with great promptitude, and with so much facility, that the patient did not know that I was doing more than making an ordinary examination. Some have advised, that we should keep up the forehead during a pain, to make the vertex descend ; or that we should, with the finger, depress the occiput.

The fontanelle, or crown of the head, may also present, although the face be turned to the sacro-iliac junction. In this case it is felt early, and, by tracing the coronal suture, we may ascertain whether the frontal bones lie before or behind. It is a much more uncommon presentation than that noticed above. The labour is, at first, a little slower than

in a natural presentation, but, by degrees, the head becomes more oblique, the vertex descending; and this may be assisted, by supporting the forehead with the finger during a pain. Should any untoward accident require the delivery to be accelerated, we have been advised to turn the child, and in doing so to use the left hand, if the occiput lie to the left acetabulum, and *vice versa*. But this operation can seldom be requisite.

The crown of the head may also present with the face to the pubis or the sacrum, but these positions are extremely rare. In time, the head will generally become more diagonal, and descend obliquely, but we ought not to trust to this. We should rectify the position, for it is by no means difficult to move the head with the finger, if we attempt it early. We may even carry the forehead from the pubis to the sacro-iliac junction. The process is still more simple when the occiput is turned to the pubis, if we perform it early. If, however, we neglect it, we find that in a few instances the head does not turn at all, but enters the pelvis in the original direction, and becomes wedged, requiring the use of instruments. This is oftenest the case when the occiput is turned to the pubis; for the forehead being broad, does not by a continuance of labour slip to the side of the promontory of the sacrum, so readily as the occiput would do.

2d. The side of the head may present. In this case, the presentation is long of being felt, but it is recognised by the ear. If, however, it has been long pressed in the pelvis, it is extremely difficult to determine the case. It is very rare, and has even been deemed to be impossible. In some instances the child has been turned, but it is most common to rectify the position of the head by introducing the hand.

3d. The occiput may present, the triangular part of the bone being felt at the os uteri. It is known by its shape, by the lambdoidal suture, and its vicinity to the neck. The forehead rests on some part of one of the *psoæ* muscles, and from this oblique position of the head, the labour is tedious. It has been proposed, in this case, to turn; but it is better, if we do any thing, to rectify the position of the head with



the hand. Nature is, however, adequate to the delivery, even if not assisted. Some advise, that the woman should, by a change of position, endeavour to remedy the obliquity, making the child incline, so as to affect the situation of the head, but this has not much power in altering the position of the presentation, at least after the water has been evacuated.

4th, The face may present, with the chin to one of the acetabula, or to the sacro-iliac junction, or to the pubis or sacrum. The two first are the best, the second is more troublesome, and the last is worst of all. When the face presents, the labour is generally tedious and painful, for it is little compressible, and affords a broad surface, not well calculated to take the proper turns in the pelvis. The head, also, being thrown back on the neck, a larger body must pass, than when the chin is placed on the breast. By a continuance of the pains, the face becomes swelled; and although at first it was recognizable by the mouth and features, yet now it is indistinct, and has been taken either for a natural presentation or the breech. By rude treatment, the skin may be torn; and even under the best management, the face, when born, is very unseemly, and sometimes quite black and elongated, so that it has been known to measure nearly seven inches. This is especially the case when the chin is directed to the sacrum, and some children die from obstructed circulation, owing to the continued pressure on the jugular veins.

Face presentations have been attributed sometimes to convulsive vomiting, cough, or frequent examination, but generally no evident cause can be assigned; and in the beginning of labour, the face itself does not present, but only the forehead: hence Le Motte tells us, that although at first he found the head present properly, yet, when the membranes broke, the face came down.

Some have advised, that the child should be turned; others, that the chin should be raised up, to make the upper part of the face come down; or that if the head be advanced, a finger should be inserted into the mouth, to bring down

the jaw under the pubis. Others leave the whole process to nature; but many endeavour with the hand to rectify the position.

If the presentation be discovered early, there can be little doubt as to the propriety of rectifying the position, but if the labour be advanced, this is difficult; and then it only remains that we should endeavour, if the labour be severe and tedious, to make the face descend obliquely, by cautiously but firmly supporting with a finger, during the pains, the chin or end which is highest, in order to favour the descent of the lower end. When the chin has advanced so far as to come near the arch of the pubis, we may follow a different method, and gently depress it, which assists the delivery, for generally the chin is first evolved. If, however, the process go on regularly, and tolerably easy, we need not make these attempts. As the perinæum is much stretched, we must support it, and avoid all hurry in the exit of the head.

When the chin is directed to the sacrum, the labour is sometimes so tedious as to require the application of instruments.

#### ORDER SIXTH.

Sometimes the cord descends before, or along with the presenting part of the child. This has no influence on the process of delivery, but it may have a fatal effect on the child; for, if the cord be strongly compressed, or compressed for a length of time, the child will die, as certainly as if respiration were interrupted after birth. If the cord be discovered presenting before the membranes burst, or if the os uteri be properly dilated when they burst, the best practice is to turn the child. It has indeed been proposed, to push the cord beyond the presenting part, or hook it upon one of the limbs; but, if the hand is to be introduced so far, it is better at once to turn the child.<sup>2</sup> If the os uteri be not sufficiently relaxed, we must not use force to expand it; and little can be done, except by rest, to prevent as much as possible, the evacuation of the water. As soon as the os uteri will admit the introduction of the hand, the child should be turned

if it can be easily done. But if the presentation be advanced before we are called, and turning be difficult, then we must endeavour to keep the cord slack, or remove it to that part of the pelvis where it is least apt to be compressed; or it will be still better, to endeavour with two fingers to push the cord slowly past the head, and prevent it for two or three pains from coming down again. This is less violent, and safer, than attempts to turn in an advanced stage of labour. Should this not be practicable, and the pulsation suffer, or the circulation be endangered, we must accelerate labour by the lever or forceps. If the pulsation be stopped, and the child dead, when we examine, then labour may be allowed to go on, without paying any attention to the cord. The sum of the practice then is, that when the os uteri is not dilated, so as to permit of turning, we must not attempt it; when turning is practicable, it is to be performed. When the head has descended into the pelvis, the cord is to be replaced, or secured as much as possible from pressure; but if the circulation be impeded, the woman must be encouraged to accelerate the labour by bearing down, or instruments must be employed. When the presentation is preternatural, these directions are likewise to be attended to, and the practice is also to be regulated by the general rules applicable to such labours.

#### ORDER SEVENTH.

Various signs have been mentioned, whereby the presence of a plurality of children in utero might be discovered, previous to their delivery. These are, an unusual size, or an unequal distention of the abdomen, an uncommon motion within the uterus, a very slow labour, or a second discharge of liquor amnii during parturition. These signs, however, are so completely fallacious, that no reliance can be placed upon them, nor can we generally determine the existence of twins, until the first child be born. Then by placing the hand on the abdomen, the uterus will be found large\*, if it

\* In a case related by Mr Aitken, the uterus was felt, after delivery, large and hard, as if it contained another child, but none was discovered. In the course of a fortnight the tumor gradually disappeared. *Med. Comment.* Vol. II. p. 300.



contain another child ; and, by examination per vaginam, the second set of membranes, or some part of the child, will be found to present. This mode of inquiry is proper after every delivery.

Soon after the first child is born, pains usually come on, like those which throw off the placenta, but more severe ; and they have not the effect of expelling it, for it is generally retained till after the delivery of the second child. No intimation of the existence of another child is to be given to the mother, but the practitioner is quietly to make his examination, rupture the membranes, if they have not given way, and ascertain the presentation. If it be such as require no alteration, he is to allow the labour to proceed according to the rules of art, and usually the expulsion is very speedily accomplished. If the first child present the head, the second generally presents the breech or feet, and *vice versa* ; but sometimes the first presents the arm, and, in that case, when we turn, we must be careful that the feet of the same child be brought down. This one being delivered, the hand is to be again introduced, to search for the feet of the second child, which are to be brought into the vagina, but the delivery is not to be hurried.

It sometimes happens, that after the first child is born, the pains become suspended, and the second is not born for several hours. Now this is an unpleasant state, both for the patient and practitioner. She must discover that there is something unusual about her, and he must be conscious that hemorrhage, or some other dangerous symptom, may supervene. The first rule to be delivered is, that the accoucheur is upon no account to leave his patient till she be delivered. The second regards the time for delivering. Some have advised that the case be entirely left to the efforts of nature, whilst others recommend a speedy delivery. The safest practice, perhaps, will lie between the two opinions. If effective pains do not come on in an hour, the child ought to be delivered by turning. The forceps can seldom be required ; for if the head have come so low as to admit of their application, the delivery most likely will be accomplished without assistance.

If, however, the position of the second child be such as to require turning, we are to lose no time, but introduce the hand for that purpose, before the liquor amnii be evacuated, or the uterine action begin to act strongly on the child. Turning, in such circumstances, is generally easy. When the child presents the breech or feet, the directions formerly given, respecting these presentations, are to be attended to.

In the event of hemorrhage, convulsions, or other dangerous symptoms, supervening between the birth of the first and second child, the delivery must be accelerated, and managed upon general principles.

When there are more children than two, the woman seldom goes to the full time, and the children survive only a short time. There is nothing peculiar in the management of such labours.

It still remains to observe, that we ought to be peculiarly careful in conducting the expulsion of the placenta of twins. Owing to the distension of the uterus, and its continued action in expelling two children, there is a greater than usual risk of uterine hemorrhage taking place. The patient must be kept very quiet and cool, gentle pressure should be made with the hand externally on the womb, and no forcible attempts are to be permitted, for the extraction of the placenta, by pulling the cords. If hemorrhage come on, then the hand is to be introduced to excite the uterine action, and the two placentae are to be extracted together. The application of the bandage, and other subsequent arrangements must be conducted with caution, lest hemorrhage be excited.

The placenta are often connected, and therefore they are naturally expelled together, but this adds nothing to the difficulty of the process. Sometimes they are separate, and the one is thrown off before the other; or it may even happen, that the placenta of the first child is expelled before the second child be born, but this is very rare, and is not desirable.

Women, who have born a plurality of children, are more disposed than others to puerperal diseases, and must there

fore be carefully watched. It rarely happens, that they are able to nurse both children without injury.

It is possible for two children to adhere, or for one child to have some additional organ belonging to a second, as, for example, an arm or an head. Such cases of monstrosity may produce considerable difficulty in the delivery; and the general principle of conduct must be, that when the impediment is very great, and does not yield to such force as can be safely exerted, by pulling that part which is protruded, a separation must be made, generally of that part which is protruded, and the child afterwards turned, if necessary. Unless the pelvis be greatly deformed, it will be practicable to deliver, even a double child, by means of perforation of the cavities, or such separation as may be expedient, and the use of the hand, forceps, or crotchets, according to circumstances. A great degree of deformity may render the cæsarean operation necessary.

With respect to children who are monstrous from deficiency of parts, I may take the present opportunity of observing, that no difficulty can arise, during the delivery, except in ascertaining the presentation, if the malformation be to a great extent, as, for instance, in acephalous children.

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## CHAP. V.

### *Of Tedious Labour.*

#### ORDER FIRST.

IF the expulsive force of the uterus be diminished, or the resistance to the passage of the child be encreased, the labour must be protracted beyond the usual time, or a more than ordinary degree of pain must be endured.

Tedious labour may occur under three different circumstances :

*First,* The pains may be from the beginning weak or few, and the labour may be long of becoming brisk.

*Second,* The pains during the first stage may be sharp and



frequent, but not effective; in consequence of which the power of the uterus is worn out before the head of the child have fully entered into the pubis, or come into a situation to be expelled.

*Third,* The pains during the whole course may be strong and brisk, but from some mechanical obstacle, the delivery may be long prevented, and it may even be necessary to have recourse to artificial force.

Different causes may retard the process of parturition. The first and most obvious one, referable to the order at present under consideration, is a weak or inefficient action of the uterine fibres. This may be dependent on general debility or inactivity, but more frequently it proceeds from the state of the uterus itself. It is marked by feeble pains, which dilate the os uteri slowly, and are long of forcing down the head. But although the pains be feeble, they may produce as great sensation as usual, for this is proportioned rather to the sensibility than to the vigour of the part. It is, however, usual, when labour is protracted from this cause, for the pains to be less severe than in natural labour. They may come much seldomer, or, if frequent, they may last much shorter, and be less acute. The whole process of labour is sometimes equally tedious, but, in most cases, the delay principally takes place in one of the stages, generally in the first, if the cause exist chiefly in the uterus. If, however, it proceed from general debility, we often find, that if the first stage be tedious, the powers are thereby so exhausted, that the second can with difficulty be accomplished. Hence, although consumptive patients often have a rapid delivery, yet if the first stage be slow, the head frequently cannot be expelled without assistance. It is not always easy to say what the cause of this slow action of the uterus is. Sometimes it proceeds from contraction commencing rather prematurely; or from the membranes breaking very early, and the water oozing slowly away; or from the uterus being greatly distended by liquor amnii, or a plurality of children; or from fear, or other passions of the mind operating on the uterus; or from torpor of the uterine fibres, frequently combined with a dull leucophlegmatic ha-

bit, or with a constitution disposed to obesity ; or from general weakness of the system.

In a state of suffering and anxiety, the mind is apt to exaggerate every evil, to foresee imaginary dangers, to become peevish or desponding, and to press with injudicious impatience for assistance, which cannot safely be granted. Great forbearance, care, and judgment, then, are required on the part of the practitioner ; who, whilst he treats his patient with that gentleness and compassionate encouragement, which humanity and refinement of manners will dictate, is steadily to do his duty, being neither swayed by her fears and intreaties, nor by a selfish regard to the saving of his own time.

Some women seem constitutionally to have a lingering labour, being always slow. In such cases, unless the process be considerably protracted, or attended with circumstances requiring our interference, it is neither useful nor proper to do more than encourage the patient, and preserve her strength.

A variety of means were at one time employed for exciting the action of the uterus, such as dilatation of the os uteri, and the use of emetics, purgatives, or stimulants. A very different practice now happily obtains ; the patient is kept cool, tranquil, and permitted to repose ; the mildest drink is allowed, all fatiguing efforts are prohibited, and she is encouraged by the mental stimuli of cheerfulness and hope, rather than by wine and cordials. But, whilst in cases where the labour is only a little protracted, we trust entirely to this treatment, with the addition of a saline clyster, which is of much service, and ought seldom to be omitted, yet, where it is longer delayed, some other means are allowable, and may be necessary.

The pains in tedious labour, connected with defective uterine action, may be continuing regular, but weak, not from exhaustion, but rather from the uterus not exerting the power it has ; or there may be a tendency to remit, the pains coming on seldom. In the first of these states, we have to consider whether there be heat of the skin, full pulse, with thirst and restlessness. If so, and especially if the

os uteri be not relaxed, venesection will be of great benefit, by making the uterus act with more freedom, and its mouth yield with great readiness. We know that in most cases of uterine hemorrhage, the os uteri, even where there is no effective labour, and scarcely any pain, is not merely dilatable, but is actually dilated. In this instance, however, the benefit of evacuation cannot be derived, for the discharge injures and impairs the whole power of the uterus, and in proportion, as the os uteri is extended, the quantity of the blood which flows is increased; besides, the evacuation usually begins before labour commences, and pains do not come on till the loss of blood excite them. We learn, however, from this example, the influence of hemorrhage in relaxing the os uteri, and if we can do this without impairing the power of the womb, we have certainly a powerful mean of accelerating labour; venesection does this in certain cases. It can do no good, but much harm in cases of exhaustion, or in cases where the resistance is afforded by a contracted pelvis, and all other circumstances are right. But in cases where the parts, through which the child must pass, are rigid or dry, or hot and tender, or where the pains are great but irregular and inefficient, or the membranes have given way prematurely, the pains are sharp, but abortive, and the os uteri thick or hard, or the patient is feverish, blood-letting is safe, and may be expected to do good. That it is safe, we know from the experience of former ages and other countries, as well as from our own observation in cases of convulsions, where a great quantity of blood is taken away with present advantage and future impunity. It is, however, a remedy, which, if imprudently employed, may do much mischief. In cases of exhaustion, for instance, it must be dangerous; and in every constitution, and under every circumstance in which it would, independent of labour, be improper to evacuate, it is evident that it will be hurtful, unless we can thereby save the patient prolonged exertion and exhaustion. In natural labour it is neither necessary nor proper; in labour not greatly protracted, nor unusually severe and slow in its steps, it is not to be resorted to. It is better



to trust in these cases to the use of clysters, to gentle motion and change of posture, or to sleep, if it offer naturally, and the patient require to be recruited.

If the woman be fatigued or debilitated, and the pulse weaker than in lingering labour, we shall derive advantage from the use of a smart clyster, followed by twenty drops of laudanum, or a proportional quantity in an injection. This does not suspend the pains, but rather excites them. A similar stimulus is sometimes given by a gentle purge, but this is more slow and uncertain in its effects.

When there is a strong tendency in the pains to remit, or keep off, we are to follow pretty nearly the same conduct with regard to venesection, in the circumstances which I have pointed out, as admitting of it; but it is much more rarely required in those cases, than where the pains are less frequent. When it is employed, it either procures a remission and sleep, followed by brisk action, or it excites more immediately the pains; for whatever diminishes the resistance or obstacle, whatever produces relaxation, speedily acts as a stimulus to the uterus to contract; cordials and stimulants are more doubtful in their effect. If, however, blood-letting be improper, we give a clyster, and then forty drops of laudanum, which either makes the pains effective and brisk, or suspends them for a time, till the womb recruit.

There is another state in which the pains are weak, or remit, or are ineffective from absolute exhaustion or debility, and we distinguish this case by the weak pulse, languor, and previous fatigue, and in part by the constitution of the woman. If no urgent symptom require delivery, we must support the strength by the prudent administration of cordials and nourishment. This is the only case in which cordials are proper, and they must even here be given prudently, lest they produce a febrile state. It is also useful to suspend for a time the uterine action, and procure rest by an anodyne clyster.

If the water be discharged very early in labour, or before the pains come on, the process is often lingering, but it is not always so. The os uteri is, when we first examine, project-

ing, then it becomes flat, but the lips thick ; then they become thinner and more dilated, and presently very thin ; and the lower part of the uterus is perhaps applied so closely to the head, that at first it might be taken for the head itself. These changes may take place quickly, but they may also be very slow, the pain sharp and ineffective, and the water discharged in small quantity with each pain. The pains are severe, but produce very little effect, and often when they go off, are succeeded by a most distressing uneasiness in the back, lasting for nearly a minute after the pain. A saline clyster is of much benefit in this kind of labour ; and it is useful to press up the head, especially during the pains, to favour the evacuation of the water ; for, whenever this is accomplished, naturally or artificially, the action becomes much stronger. It is also useful to detract blood, if the os uteri be rigid, the parts not disposed to yield, and the pains very severe. It is peculiarly proper when the woman has rigors. When the organs are firm, and the pains lingering, it causes relaxation, and quickens the pains. If on the other hand, the os uteri be lax and thin, or soft, it is both safe and advantageous to dilate it gently with the finger during a pain. If this be done cautiously, it gives no additional uneasiness, whilst the stimulus seems to direct the action of the uterine fibres more efficiently towards the os uteri, which sometimes thus clears the head of the child very quickly, and the pains which formerly were severe, but in the language of the patient unnatural and doing no good, become effective and less severe, though more useful. This advice, however, is not meant to sanction rash and unnecessary attempts to dilate the os uteri, which sometimes render labour more tedious, by interrupting the natural process, and also lay the foundation for inflammatory affections afterwards.

If, again, in lingering labour, the membranes be entire, the os uteri soft, lax, and well dilated, and the presentation natural, it is allowable and beneficial to rupture the membranes ; and this is more especially proper, if the uterus be unusually distended. The evacuation of the water is succeeded by more powerful action, a circumstance which,

whilst it points out the advantage of the practice in the case under consideration, forbids its employment in natural labour, where the process is going on with a regularity and expedition, consistent with the views of nature, and the safety of the woman.

Sometimes, after the first stage is completed, and the os uteri is well dilated, the second does not commence for some hours; but the first kind of pains continue in different degrees of severity, without producing any perceptible effect. If no particular cause require our interference, it is best to trust to time; but, if it be necessary to accelerate the labour, it may often be done by rupturing the membranes, or, if they have already broken, we may place two fingers on the margin of the os uteri, which is next the pubis, and gently assist it, during the pains, to slip over the vertex.

When a woman is greatly reduced in strength, previous to labour, that process is looked forward to with apprehension. It is, however, often very easy. But, if it should be protracted, the patient is to be kept from every exertion. The general plan of treatment pointed out for such cases is to be followed, and, if the strength fail, the child must be delivered. We must be particularly careful that hemorrhage do not take place after delivery, or that it be promptly stopped.

If the head rest long on the perinæum in tedious labour, the pains having little effect in protruding it, especially if the first stage have been lingering, it comes to be a question, whether we shall deliver the woman. This case is different from that where the difficulty proceeds from a contracted pelvis, for the head is low down, the bones are not squeezed nor mishapen, there is only a swelling of the scalp, the finger can be passed round the head, and two strong pains might expel it. Whilst the strength remains good, there is no warrant for delivering. A soothing treatment, promoting rest, restraining voluntary bearing-down efforts, and giving a little wine, or an opiate, if the patient be exhausted, will generally be successful. But, if the labour be still protracted, the strength sinks, the pulse becomes weak and fre-



quent, the pains useless, the woman complains of headach, is restless, has not the full command of her mind, and sometimes vomiting comes on after every pain. In such cases, the forceps must be employed, as will hereafter be noticed. It is impossible to determine how many hours a labour may be permitted to continue, for time alone is not to be our rule; we must be regulated greatly by the effects of labour. Yet it may not be altogether useless to state the periods, at which lingering labour has terminated in a large hospital. From Dr Breen's tables it would appear, that, in the Dublin hospital, of 172 women in labour of their child, 102 were from 40 to 50 hours in labour; 34 from 30 to 40; 24 from 70 to 80; and 12 from 90 to 100; 121 children were alive. Of 91, who had born children formerly, 48 were from 40 to 50 hours in labour; 28 from 30 to 40; 9 from 70 to 80; and 6 from 50 to 60; 66 children were alive.

In tedious labour, it is not necessary to confine the woman to bed, or to one posture; she may be allowed to sit, lie, or walk, as she feels inclined; and we are not to urge her to stand long, or use exertion by way of promoting labour. She has generally not much inclination for food, but, if the process be protracted, it is useful to give some light soup, and a little wine, if she desire it. If the urine be not regularly passed in tedious labour, the catheter ought to be introduced. It is not necessary that the practitioner remain constantly with the patient. It will have a better effect upon her, if he see her at proper intervals; whilst he is thus prevented himself from being so fatigued, as he otherwise would be, and is therefore better able to discharge his duty with firmness and judgment.

The second general cause of tedious labour is, irregular action of the uterine fibres. After the child is born, the uterus sometimes contracts like a sand-glass, and retains the placenta. The same spasmodic action may occur before the child be expelled. It is marked by pain coming at intervals, like proper pains, but it is confined to the belly, and has little effect on the os uteri, or in forcing down the child. The contraction does not go off with the pain, it only lessens; hence the band of fibres still compresses the child or ovum,

and, if the membranes have not broken, they are often kept so tense, as at first to resemble a part of the child, and may mislead the practitioner with respect to the presentation. If this affection be slight, it may soon go off; but, if the spasm be strong, it sometimes continues for many hours. A smart clyster is often of great service. Blood-letting sometimes does good. Opiates I have tried, but I cannot speak with confidence of their effects, and prefer opening the membrane if the presentation be good, and the os uteri lax; this I have found very successful. But if the os uteri be rigid or undilated, and especially if the presentation be not determined, they must be kept entire, until the os uteri will permit of turning, should the position of the child require it. After the child is born, the hand should be introduced into the uterus, not to extract the placenta quickly; but to come easily in contact with it, and excite the uterus to regular action; for generally the spasm returns, and the placenta may be long retained, or hemorrhage produced.

A frequent cause of tedious labour, is a state of over-action, or unproductive action in the first stage, by which the powers of the uterus are exhausted, and the subsequent process is rendered very slow. This exhaustion may also be produced by the continuance of debilitated action or feeble and useless pains. In the first case, the pains are sharp and frequent, but do not dilate the os uteri properly, nor advance the process in general. It may be produced by irregular action of the fibres, or by premature rupture of the membranes. In the second case, the pains are lingering, short, and usually weak. I have already considered the remedies for those states; blood-letting, clysters, gentle dilatation of the os uteri, &c. and have here only to observe, that the exhaustion of the uterus, and consequently an additional prolongation of the labour is to be prevented either by suspending the pains for a time, or by rendering them more effective; and upon this subject, I refer to what I have already said in the beginning of this chapter. Unproductive action ought never to be allowed to continue so long as materially to impair the power of the womb. If we cannot safely render the action more

efficient, we must endeavour to suspend it; by which the womb recruits, and the retarding cause may in the meantime be removed, or cease to exist.

Another cause of tedious labour is, the accession of fever, with or without local inflammation. Fever is recognized by its usual symptoms, and may be produced by the injudicious use of stimulants, heated rooms, irritation of the parts, &c. It is to be allayed by opening the bowels, keeping the patient cool in bed, and giving some saline julap; at the same time that the mind is to be tranquilized: If these means do not abate the heat, frequency of pulse, &c. and render the pains more effective, it will generally be proper to detract blood, especially if the head or chest be pained. When local inflammation accompanies fever, it is commonly of the pleura or peritoneum, and is preceded by chillness and shivering. The first is discovered by pain in the thorax, cough, and dyspnoea; the second by pain in the belly, gradually increasing and becoming constant; pressure increases it, and in some time the patient cannot lie down, but breathes with difficulty, or is greatly oppressed, and vomits. The labour pains are sometimes suspended; on other occasions, they do ultimately expel the foetus, but the woman dies in a few hours. On the first threatening of these symptoms, blood should be freely detracted, the bowels opened, and a gentle perspiration excited. If the inflammatory symptoms increase, and the labour is protracted, we must deliver the woman.

Labour may also be rendered tedious, by the different stages not going on regularly, but efforts being prematurely made to bear down. In consequence of these, the uterus descends in the pelvis, before the os uteri is dilated, and the process is often both painful and protracted. In some cases, the womb prolapses, so that its mouth appears at the orifice of the vagina. This prolapsus may take place during pregnancy, or after parturition begins. It is often met with, in a slight degree, whilst the os uteri is not greatly dilated, and uniformly injures the labour. We are to prevent it from increasing, by supporting the head or the uterus with two fingers, during the continuance of a pain; at the same



time that the woman avoids, as much as possible, every bearing-down effort, and remains in a recumbent posture. If the os uteri be slow of dilating, some blood should be taken away, and an opiate administered. It has happened that, by neglecting these precautions, the uterus has protruded beyond the external parts. In this case, no time is to be lost in attempting the reduction, which will be rendered easier by cautiously pulling back the perinæum\*. If this cannot be done, the os uteri, if lax and yielding, must be gently further dilated, the membranes ruptured, the child turned, and the uterus replaced†. The os uteri has been cut, but this can never be necessary, if the structure of that part be natural. When the womb does not actually protrude, the vagina may be inverted like a prolapsus ani. A soft cloth, dipped in oil, should be placed on the part, and pressure made with the hand. Giesman cut the inverted vagina on a probe, but this operation can rarely be required. If the womb prolapse before labour, as happened to Rœderer's patient, we must manage the case as a simple prolapsus. She had severe pains, although she was not in labour.

#### ORDER SECOND.

There exists, naturally, such a proportion between the size of the head and the capacity of the pelvis, that the one can pass easily through the other. But this proportion may be destroyed, either by the head being larger or more completely ossified, or the pelvis smaller than usual. In such cases, which are to be discovered by careful examination, it is evident that the labour must be more tedious, and more painful, than it otherwise would be. The first stage of the process is sometimes, but not always slow; the second is uniformly so; the head is long of descending into the pelvis, it rests long on the perinæum, the pains are frequent, severe, and often very forcing, but the woman says they are doing no good. Now this state requires much patience and dis-

\* Vide Mem. of Med. Soc. Vol. 1. p. 213.

† Vide Portal's 10th Obs.; and Ducreux's case, in *Mém. de l'Acad. de Chir.* Tome III. p. 368. See also a case by Saxtorph.

cretion. The bowels should be opened with a laxative; the urine regularly expelled; the strength preserved by quietness, avoiding unnecessary exertion, indulging any disposition to sleep which may exist, and taking a little light nourishment occasionally; the mind is to be soothed, the hopes supported, and, if the pains begin to slacken, an opiate may be given, to procure rest. By these means, the child will be at last expelled, though, perhaps, not till the woman has been two or three days in labour. If in this, or indeed in other case of tedious labour, we find the head remain so long in the brim of the pelvis, as to obstruct the circulation in the soft parts, or irritate them, producing swelling, which is preceded by heat, dryness, and a feeling of tenderness during examination, with or without a sensation of tightness within the pelvis, and cramp in the legs, the child must be delivered *quam primum*.

Malposition of the head may likewise retard the labour; but this has already been considered.

Another cause of tedious labour is, rigidity of the soft parts, which may be dependent on advancement in life, or some local peculiarity; and these causes generally act more powerfully in a first than a subsequent labour. This rigidity may exist in the os uteri, in the external parts, or in both; and if, along with this, there be premature rupture of the membranes, the difficulty is always increased. When it exists in the os uteri, that part is very long of dilating; the effect of the pains, for a long time, is rather to soften than to dilate; and after the woman has been many hours in labour, it is found, when the pain goes off, to be collapsed, and projecting like the os uteri in the eighth month of pregnancy. In this case, the first stage is very slow, lasting sometimes two or three days; and the second is likewise tedious. The whole process takes up, perhaps, four days or more. When the rigidity exists chiefly or partly in the external parts, they are found to be at first dry, tight, and firm. By degrees, they become moister and more relaxed; but they may still be so unyielding, as to keep the head for many hours resting on the perinæum. Now in these cases,

it is to be recollected, that generally time and patience will safely terminate the labour. When the head reaches the perinæum, if the pains be trifling or ineffective, it is of service to keep the woman for some time in a kneeling or erect posture. Some methods have been proposed for abating the rigidity; such as baths, fomentations, and oily applications; or digitalis and sickening medicines given internally; but these have no good effects, and some of them do harm. Blood-letting has been employed in such cases. Dr Rush informs me, that in America, it has been used with great advantage; and Dr Dewees has politely sent me a dissertation on this subject, which contains very good cases of its efficacy, when pushed freely. In some instances, fifty ounces were taken away before the parts relaxed. In determining on the use of blood-letting, we must attend to the state and habit of the patient. Debilitated women\*, and those who are exhausted by fatigue, especially among the lower classes in large cities, are injured rather than benefited by this practice. Robust women, of a rigid fibre, in the middle class of society, or who live in the country, bear blood-letting better, and derive more benefit from it. In them it is especially proper, if any degree of fever attend the labour, and in all cases when the parts are rigid, if the patient be not previously reduced, or very delicate, blood should be detracted *pro viribus*. If, however, the state of the patient forbid this, an opiate clyster may be substituted.

In some cases, the os uteri or external parts, instead of being rigid, are tumid, and apparently œdematous. In these the labour is often protracted for several hours, especially when the os uteri is affected. In tedious labour, the os uteri sometimes becomes swelled, as if blood were effused into its interstices. This requires venesection.

The os uteri may be naturally very small. In some instances, it has with difficulty admitted a sewing needle; and in two cases, during labour, I found it almost impervious,

\* Dr Dewees bleeds even delicate women, and those who are disposed to faint on being bled, but takes a smaller quantity from them.



hard, circular, and with difficulty discovered; but it gradually dilated. Venesection is in this state of service. Sometimes it is hard and scirrhus, so that it has been deemed necessary to make an incision into the os uteri, to make it dilate\*. It is also possible for the os uteri to be closed in consequence of inflammation, so that it has been necessary to make an artificial opening†.

Contraction and cicatrices in the vagina, likewise retard labour, and cause very great pain until they either relax or are torn, but it is seldom necessary to perform any operation. If it should, they must be cut.

Excrecences proceeding from the os uteri, an enlarged ovarium remaining in the pelvis, or tumors attached to the ligaments, or a stone in the bladder, may all obviously retard the labour, some of them so much as to require instruments. A stone in the bladder ought either to be pushed up beyond the head, or extracted.

A small vagina may require a long time to be dilated.

A great degree of obliquity of the uterus protracts labour. The os uteri may be turned very much to one side, but oftener it is directed backwards and upwards, and may be out of the reach of the finger. Time rectifies this.

Malformation of the organs of generation may afford great obstacle to the passage of the child, so that even the incision may be required, as happened in the case related by Mr Bonnet, in the thirty-third volume of the Philosophical Transactions.

By shortness of the umbilical cord, or still more frequently, by the cord being twisted round the neck, the labour may be retarded, particularly the latter end of the second stage. The cord may be on the stretch, but it never happens that it is torn, and very seldom that the placenta is detached. We have no certain sign of the existence of this situation; but there is presumptive evidence of it, when the head is drawn up again upon the recession of each pain.

\* A case of this kind occurred to Dr Simson of St Andrews, and another to a practitioner in America.

† Vide Case by Campardon, in *Recueil Period.* Tom. XII. p. 277.

It often remains long in a position, which we would expect to be capable of very quick delivery. By patience, the labour will be safely terminated; but it may often be accelerated, by keeping the person for some time in an erect posture, or on her knees. After the head is born, it is usual to bring the cord over the child's head, so as to set it at liberty; and this is very proper when it can easily be done, as it prevents the neck from being compressed with the cord in the delivery of the child, by which the respiration, if it had begun, would be checked, or the circulation in the cord be obstructed. Some have advised that the cord should be divided, after applying the double ligature; but this is rarely necessary, for the child may be born, even although the cord remain about the neck.

Preternatural strength of the membranes has been considered as a cause of tedious labour, and we have accordingly been desired to tear them. This is, however, very seldom the case. When they remain long tense, it is oftener from spasm of the uterus than from firmness of structure.

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## CHAP. VI.

### *Of Instrumental Labours.*

#### ORDER FIRST.

THE head may be enlarged by disease, or the capacity of the pelvis may be considerably diminished, by causes which have been noticed in the beginning of this work. Then, from the pressure of the head upon the soft parts in the pelvis, and the forcible but opposed efforts of the uterus, severe pain is produced, and the sufferings of the patient are protracted in proportion to the resistance which is to be overcome. Now we have to consider the danger of such a case, and to recollect the cause of this danger. It proceeds from the pressure of the child upon the soft parts of the mother, which, within a certain period, must produce that kind of inflammation which is speedily followed by sloughing. Besides this source of risk, there is ground for alarm, lest the

uterus should burst ; or abdominal inflammation supervene ; or a suppression of urine take place ; or the system become irreparably exhausted, in consequence of long and severe exertion. These dangers are not all equally frequent in their occurrence, nor do they take place in the same degree in every case. It is however evident, that if the resistance cannot be overcome, and the child be born, one or more of these causes must destroy the mother ; whilst the long continued pressure upon the child, the consequent injury which the head sustains, and the interruption which may be given to the circulation, must prove fatal to her offspring. But we likewise know, upon the other hand, that the regular and continued efforts of the uterus can overcome a very great resistance, and that these efforts, within certain limits, are safer for the mother, and more favourable to the child, than the application of artificial force. We should, therefore, lay it down as a general rule, that when the deformity is not excessive, and no urgent symptom is present, we should fully ascertain what the uterus can do, before we assist it. We know, that if the pelvis measure, in its short diameter, only three inches and a half, then we must have a painful and difficult labour, because, as the head measures as much in its lateral extent, it must be compressed more or less, in order to pass. If the brim, however, measure only three inches, then the head of a child at the full time cannot pass, until it has been pressed so long as to diminish its breadth fully half an inch. The more, then, that the brim is reduced below its natural dimensions, the longer and the more painful must the labour be, until we come to such a degree of contraction, as will either render expulsion altogether impossible, or delay it until great danger has been induced.

It is difficult to draw the line of distinction betwixt that degree of contraction which will render it impossible for delivery to take place naturally, and that which will only render it extremely difficult. It has been proposed to ascertain this, by a rule founded on the dimensions of the pelvis. But this method cannot be brought to a sufficient degree of perfection, for the result of cases is much influenced by



the size of the child, the pliability of its head, the vigour of the uterus, and other causes. Besides, it is difficult, if not impossible, to determine, with minute precision, the dimensions of the pelvis in the living subject; and they are apt to vary, according as the soft parts within the pelvis are more or less swelled. We shall find it better to judge by the progress which the head has been able to make. If it has not been able to enter the pelvis, or if only a very small part, after great exertion, has been able to enter, then it is not possible for the woman to bear the child, or even to have it brought through entire by the forceps or lever, for these instruments either could not be applied, or, if applied, the resistance would be so great as to prevent their success. It has therefore been laid down as a general rule, that these instruments, and especially the forceps, ought not to be applied, until the os uteri is fully dilated, and the head so low down as to come in contact with the perinæum, and to make it easy to feel an ear. The first part of the rule must always be attended to, and the second is seldom to be dispensed with. It has, indeed, been proposed to increase the length of the forceps, so as to operate with them, whilst the greatest part of the head remained above the brim of the pelvis; but the practice is dangerous and difficult, in proportion to the height of the head. The lever may be applied, and safely acted with, when only a third part of the head has entered the pelvis, and consequently before the forceps can be advantageously employed. Nevertheless, necessity, and not choice, leads us to the use of the lever in that situation. Hemorrhage or convulsions may require it; but in cases of simple contraction of the pelvis, unattended with these symptoms, the lever ought not to be applied until we have fully ascertained that the head cannot be forced any lower. As long as the pulse is good, and the pains are strong, and produce any effect upon the head, we ought not to interfere. It is the natural consequence of continued uterine action, that after a time the womb should become fatigued, and the pains cease or decrease. I must, however, remind the reader, that the pains may very early

become suspended, even in natural labour, for hours, without any obvious cause, and without the smallest appearance of danger. No practitioner of discernment can be misled by this, when all other circumstances are natural; but if the pelvis be a little contracted, he must be careful to ascertain that the cessation really has proceeded from previous exertion, and not from a temporary cause. When the action flags, and there is no appearance of the fibres recruiting soon, when the woman is much fatigued, and perhaps the pulse frequent and feeble, we can gain no more from delay; we have ascertained what nature can, and what she cannot accomplish. In this case, the head is fixed in the pelvis, the uterus cannot force it down, and the accoucheur can scarcely, if he were willing, raise it up. It is said to be impacted, or locked in the pelvis, for it is immoveable; and at the same time, from the pressure, the soft parts are tumified, the presentation sometimes distorted, and the bones may be felt making an acute angle with each other. When the pelvis is contracted or deformed, the bones of the cranium gradually yield, and the head is often lengthened very considerably. In every case where pressure is applied, the parietal bones form a more acute angle with each other, their protuberances approaching nearer together, so that, in some instances, the transverse diameter from the one protuberance to the other does not measure above two inches and a half; but the head is not always lengthened in the same proportion. Sometimes, the bones sliding one under the other, its length is even diminished. Children have been brought to me, where, either from the application of instruments, or the action of the uterus, the bones have been separated, and the one parietal bone forced completely beneath the other. From gradual swelling of the integuments, the head sometimes appears to advance when the bones are really stationary. Now, when the head is stationary, and especially if the pains have declined, there is great danger in longer delay, for it is sometimes difficult, if not impossible, to have the bladder emptied; and such injury may be done to the urethra, bladder, and rectum, as to cause sloughing.

There is another state which may require delivery, but which admits of longer delay. In this case, the head is not locked in the pelvis, but, after entering it, is stopped or arrested for a long time, either by a slighter deformity at the brim than that which produces locked head, or by some contraction of the outlet, or undue projection of the spines of the ischia, or in consequence of feeble or irregular action of the uterus, produced by various causes. In this case, the head is not absolutely immoveable, the finger can be passed more freely round it than in the former case, and it may advance a little during a pain, and recede when it goes off. Delay, in this case, is not attended with the same risk of injury to the contents of the pelvis; and we may safely trust to time, light nourishment, mild cordials and rest, untill the flagging or cessation of the pains prove that the delivery cannot be expected from the powers of nature. It is necessary carefully to distinguish betwixt the paromphosis or locked head, and the case of arrest, for delay is safer in the latter than in the former. Some practitioners of great experience, justly afraid of the rash application of instruments, have perhaps spoken too indifferently on this subject. Dr Osborn observes, that in the state indicating the use of the forceps, "all the powers of life are exhausted, all capacity for farther exertion is at an end, and the mind as much depressed as the body, they would at length both sink together under the influence of such continued but unavailing struggles, unless rescued from it by means of art." Now in cases of locked head, this principle, if fully acted on, must often be attended with dangerous consequences; and even if restricted to cases of arrest, I must consider it as by far too strongly expressed.

When the head is locked or firm in the pelvis, and does not advance, we must deliver. The precise time, however, at which we must interfere, cannot be determined by any absolute rule laid down in a system. We have been told that the head must be allowed to rest on the perinæum for six hours, and then we are to deliver. But much must depend on the state of the pains, and the contraction of the



pelvis. It is possible, that before the action of the uterus be nearly exhausted, the cervix may be ruptured; and therefore, in a contracted pelvis, when the pain is very severe, and chiefly felt in one spot, as the sacrum or pubis, when it is acute but unproductive, and the head firmly wedged, the probability of this dreadful accident taking place is so great, as to make it proper to deliver. When the urine is long retained, and cannot be drawn off, we must also interfere sooner than we otherwise would have done. But when the bladder is not distended, the uterus not firmly intercepted between the head of the child and the pelvis, the pains strong and forcing, or not suspended from weakness, and the general strength good, we ought to delay. As long as the pains have any effect, however small, in pressing down the head, and no dangerous symptom appears, we are warranted in trusting still to nature. But when they flag, and the head, after a severe or tedious labour, remains for some hours stationary, it would be dangerous to leave the woman longer undelivered. If the soft parts become swelled; or if they be dry, hot, and tender, a state which precedes swelling, the child must be delivered; nay, in, some cases, even the crotchet may, from the tenderness and swelling, require to be employed, although the pelvis be not exceedingly deformed. Delay produces inflammation, ending in gangrene. Some, amongst whom is M. Baudelocque, advise, that whenever the head is locked, the woman should be delivered; and this advice is, upon the whole, a good one, if we be careful to confine the term "locked" to that state in which the head cannot be depressed by the pains, or raised by the hand; for then there is not only great risk of the uterus being ruptured, but also of the soft parts sloughing.

Too long delay, as well as the rash and early use of instruments, may prove fatal to the child.

It is very distressing to attend during the continuance of a severe and protracted labour, and in many cases, it is peculiarly delicate to propose the means of relief. Women have naturally a dread of instruments; the very name in-

spires terror, and whatever may be said to the contrary, we know that their use is attended with pain proportioned to the obstacle to be overcome. Some patients urge the adoption of any means which can abridge their suffering, and are inclined to submit to delivery, in cases where the practitioner can by no means give his consent. But in general an opposite state of mind prevails, and it is not until after much distress that the patient is reconciled to the use of instruments. The result of a labour is for many hours uncertain; on this account, as well as from motives of humanity, no hint ought, in the early part of the process, to be given, of the probability of instruments being required. But as their necessity becomes more apparent, and the time of their application draws nearer, it will be proper to prepare the mind of the relations for what may be necessary, if the delivery be not naturally accomplished. With regard to the patient herself, we must proceed according to her disposition. If she be from what we have already learned, strongly prepossessed against interference, it will be necessary to give such prudent hints, and such explanations of the practice as relating to others, though not to herself, as will prepare her for her consent. But if we can perceive that she is disposed to agree readily to whatever may be necessary, nothing ought to be said till very near the time, as the anticipation of evil is often as distressing as the enduring of it. When we are to deliver, it is useful to explain shortly and delicately what we mean to do, which has a great effect in calming the mind.

When the pelvis and the child were of a disproportionate size, it was the practice before the forceps were discovered, to endeavour to turn the child, and deliver by the feet, which allowed the practitioner to use considerable force in pulling out the head. But if the resistance was great, the child was killed in the attempt, and often had the body torn away from the head, which was left in the uterus. This gave rise to many inventions and directions for the delivery of the head in these circumstances. If, on the other hand, the child could not be turned, the head was opened, and

the crotchet employed. To avoid turning, fillets were used by some; but no material improvement was made in practice, until the discovery of the forceps and the lever, one or other of which was<sup>1</sup> used first in Britain, by Mr Chamberlain, about the middle of the seventeenth century. Others afterwards employed them, but still advised turning in preference, if the situation of the head permitted. Turning is now abandoned, and the only point under discussion by accoucheurs is, whether the forceps or lever ought to be preferred. I apprehend, that when the head has descended pretty low, and especially in cases of arrest, the forceps may be employed with great advantage; but when the head has not advanced so far as to have more perhaps than a third within the brim, the lever will be more advantageous, unless we use long forceps. The chief superiority, then, of the lever is, that it can be used earlier than the common forceps; for when the head has come low down, either instrument may be employed, with success and safety, by a practitioner accustomed to the application, and well acquainted with the mode of action. There is then only one case in which I admit the lever to be more useful than the common forceps, and this of necessity rarely occurs. In the hands of a prudent and expert operator, each instrument is safe and capable of completing the delivery. But in making a comparison of the properties of the lever and forceps, in order to assist my pupils in their choice, I have long given it as my opinion, that a young practitioner would be less apt to injure the woman, and less likely to be foiled in his intention, with the forceps, than with the lever, in the generality of cases; for if the forceps be once properly applied, he cannot fail in accomplishing the delivery; but although the lever be applied, he may, if embarrassed, go wrong, and press too much on the soft parts. It has been said, that it is more difficult to introduce the forceps than the lever, for there are two blades in the one case, but only one in the other. We know, however, that the chief difficulty is met with in applying the first blade, and that the second is introduced in general, very easily. After a little experience, the practi-



tioner may operate with equal facility, and certainly very safely with either instrument; nor do I consider it at all as a point of honour, that he should uniformly confine himself to one in preference to the other; for cases may occur in which particular circumstances may incline him to make use of that instrument which he is least in the habit of employing. Students ought to acquire the power of using both the lever and the forceps.

When the lever is to be employed, we are to apply the extremity of the instrument on the mastoid process of the temporal bone\*, or side of the occiput. The woman may be placed on her left side, in the usual posture; and we then, with the fore finger of the right hand, feel for that ear which is next the pubis, and take it as our guide in passing the lever. Three directions must be particularly attended to. The first is, to keep the point of the instrument, during the introduction and operation, close to the head of the child, lest the bladder or rectum be injured. The second is, that the concavity of the instrument be kept in contact with the curvature of the head, by which it will be much more easily introduced than if it be separated to an angle from the head. It will, therefore, be necessary to keep the handle back toward the perinæum, in the beginning of the process; and it will be useful, especially to the young practitioner, to have more than one lever of different degrees of curvature, for he may sometimes be able to introduce one which is very little bent, when one more concave will be applied with difficulty. It is a general remark, that within a certain range, the greater the curvature, the more is the difficulty of introducing it, but the greater is its power over the head. The third is, to attend the axis of that part of the pelvis, in which the head is placed, and pass the instrument in that course. In the usual position, the blade will be placed behind the symphysis pubis, or perhaps a little obliquely, and the handle will be directed back towards the perinæum. As the blade is curved

\* This process is very indistinct in the fœtus, but the direction may still be retained, as it refers to a well known spot.

at its extremity, and as, in order to get it passed, its surface must be kept in contact with the head, it will be requisite to direct the handle more or less backward, according as the blade is more or less curved; and when it is introduced, the handle will be brought farther forward.

When we act with the instrument, we must not make any part of the mother a fulcrum; and indeed, whatever fulcrum be employed, we ought not to raise the handle much, or suddenly, in order to wrench down the head. Instead, at first, of raising the handle considerably, we rather attempt to draw down the head, as Mr Giffard did with the single blade of his extractor, using the instrument more like a hook or tractor, than a lever. With the left hand placed upon the shank of the blade, we press it firmly against the head, which both prevents it from slipping, whilst we draw down with the right hand grasping the handle, and also serves as a defence to the urethra, should the handle be a little too much raised like a lever. At first, we should pull or act with the instrument gently, to see that it is well fixed, or adapted to the head. Afterwards we act with more force, but not rashly or unsteadily. These attempts will renew the pains if they had gone off, and then they ought only to be made during the continuance of a pain; for every practitioner knows, that the co-operation of pains adds prodigiously to the utility of the instrument. The head being brought fully into the pelvis, and the face turned into the hollow of the sacrum, we must act in the direction of the outlet; and for this purpose, it will be useful to withdraw the instrument, and apply it cautiously over the chin, which, as less force is now necessary, will not suffer by the operation. Or the forceps may now successfully be applied, and should be used whenever there is necessity for a speedy delivery. Sometimes the natural pains will, without any farther assistance, finish the delivery. We must be careful of the perinæum.

When the forceps are used at first, instead of the lever, we must, in like manner, take the ear for our guide, passing the first blade over that side of the head which lies to the

pubis\*. With the finger of one hand we feel for the ear next the pubis, whilst with the other hand we introduce the blade into the vagina, the handle being directed very much backward. We then cautiously insinuate the blade along the head, and over the ear, moving it upwards with a gentle, wriggling motion, until it slip between the head and the pubis. It is then to be moved on till we suppose its point to be applied over the chin. In this way, the blade follows a line drawn from the vertex to the chin, crossing over the ear. The second blade is to be introduced behind, on the opposite side of the head, and must follow a corresponding line upon it. After this, the handles are to be locked; and in doing this the first blade must often be withdrawn a little to be adapted to the second. They ought not to be tied. I beg it to be remembered, that in the introduction of the blade, both its point and its hollow surface must be kept in close contact with the head, as it passes on, otherwise the bladder may be perforated, or the uterus torn, by one who overcomes resistance, not by art, but by force. The blade must be passed in the direction of the axis of the brim of the pelvis, and when the instrument is locked, the handles are inclined backward. If the handles do not join easily, or if they be not placed on corresponding lines, we cannot act; but must adjust one of them before operating. It is apparently unnecessary to direct that no part of the mother be included in the lock, but it is of importance to attend to this in practice. The introduction of the forceps is sometimes followed by a gush of liquor amnii, which may be foetid and tinged with meconium, although the child be alive.

In this process, we must be deliberate and cautious. We must never restrict ourselves in point of time, nor promise that it shall be very speedily accomplished. If we act otherwise, we shall be very apt to do mischief, or, if we find difficulty, to abandon the attempt. When the pelvis is so con-

\* I believe that the short forceps, with a single curve, are as useful, and more easily applied, than those which have the blades curved laterally. But if these should be employed, then they must be so introduced, that the convex edge of the blades shall be next to the face.



tracted as to make it just practicable to introduce the forceps or lever, that part of the head which is above the pubis sometimes projects a little over it, so that we cannot pass the blade until we press backward a little, with the finger, on that part which we can reach. All attempts to overcome the resistance by force, every trial which gives much pain, must be reprobated. But, on the other hand, as long as his conduct is gentle and prudent, the young practitioner must not be deterred because the patient complains, for the uterine pains are often excited by his attempt; or some women, from timidity, complain when no unusual irritation is given to the parts. Slow, persevering, careful trials, must be made; and I beg, as he values the life of a human being, and his own peace of mind, that he do not desist, and have recourse to the crotchet in cases at all doubtful, until it has been well ascertained that neither the lever nor forceps could be used.

The instrument being joined, we pull it downward, and move it a little, to ascertain that it is well applied. We then begin to extract, taking advantage of the first pain. If the pains still continue, we pull the instrument downward, and, at the same time, move the handle a little forward, toward the pubis; and then, after halting a second, move it slowly back again, still pulling down. We must not carry the instrument rapidly or strongly forward or backward, against the pubis or perinæum, but the chief direction of our force should be downward, in the direction of the axis of the brim. The motion of the pendulum kind is intended to facilitate this, but, if performed with a free, rapid, and forcible swing; the soft parts must be bruised, and great pain occasioned. The operation of extracting is not to be carried on rapidly, or without intermission; on the contrary, we must be circumspect, and imitate the steps of nature. We must act and cease to act alternately, and examine, as we go on, the progress we are making, and also ascertain that the instrument is still properly adapted to the head. The head being made to descend, the face begins to turn into the hollow of the sacrum, and, in the same degree, the handles must move round on their axis; and when the face is

thrown fully into the hollow, the handles must be turned more forward and upward, being placed in the axis of the outlet. The pendulum kind of motion must now be very little, and is to be directed from one ischium toward another. As the head passes out, the handles turn up over the symphysis pubis. In this stage, we must proceed circumspectly, otherwise the perinæum may be torn.

If the fontanelle present, the blades of the forceps are to be placed directly over the ears. If the lever be used, its point will rest on, or near, one of the mastoid processes. If the face present, the lever will rest on the back part of the temporal bone, or on the occipital bone; the forceps will have their points directed toward the vertex, but in face cases, the lever being less apt to slip, is preferable.

If the forceps or lever be injudiciously introduced, the bladder or uterus may be perforated; or if the head be allowed to remain too long jammed in the pelvis, some of the soft parts may slough. The under and posterior part of the bladder is apt to slough off leaving the woman incapable of retaining her urine. This is best prevented, by being extremely attentive in every case, especially in those where the soft parts have suffered much, or long from pressure, to evacuate the urine regularly twice a-day, employing, if necessary, the catheter. The parts ought also to be kept very clean, and may be frequently bathed with decoction of chamomile flowers.

#### ORDER SECOND.

It unfortunately happens, that sometimes the pelvis is so greatly deformed, as not to permit the head to pass until it has been lessened by being opened.

It is universally agreed, that a living child, at the full time, cannot pass through a pelvis whose conjugate diameter is only two inches and a half. It has even been stated, by high authority, that if the dimensions were "certainly under three inches, a living child could not be born;" but although this opinion be too frequently correct, yet, like all other general rules, it has exceptions, depending on the original size and

peculiar constitution of the child, together with the pliability of the cranium, on the particular shape of the pelvis, and the force and activity of the uterus, as well as the general strength of the woman. There have been instances, where, by the efforts of nature, living children have been expelled through a pelvis scarcely measuring three inches; and there are similar examples of the delivery being, under the same conformation accomplished with the lever\*. We are not warranted, therefore, to open the head, merely because we estimate that the pelvis does not, in its conjugate diameter, measure fully three inches; but because we have ascertained by a sufficient trial, that the uterine action cannot force down the head, and that the vectis cannot be applied or acted with effectively. In all cases where the dimensions and circumstances of the case are barely such as to warrant a belief that the head must be opened, an attempt ought previously to be made, not in a careless or hasty manner, but deliberately and attentively, to introduce and act with the vectis, or forceps.

We may, however, if the dimensions be much under three inches, be assured, that delivery cannot be accomplished without the destruction of the child. But as it is a matter of great nicety to say whether the pelvis measures three inches, or only two and a half, or two and fourth, a practice founded on arithmetical directions must be unsafe. In every case, therefore, we ought to allow some time for the pains to produce an effect; and this time should be longer or shorter, according as, in our estimation, the dimensions diminish from three inches to two inches and a half. In such extreme deformity as this, we have no reason to expect that the head can pass, unless it burst †, or be artificially opened; and therefore it

\* M. Baudelocque relates a most interesting case, where there were decided marks of the fœtus being dead in utero, and yet these were delusive, for, by the forceps, the woman was delivered of a living child, although the pelvis measured only about three inches. *L'Art des Accouch.* § 1898.—Cases in point may also be seen in Dr Alexander Hamilton's Letters, p. 94. 102. 113.—Similar instances have come within my own knowledge.

† So far as I can judge, the sutures yield sooner than the scalp, and the brain is effused, or pushed out like a bag. When the integuments open first, it is owing, I apprehend, to sloughing from pressure and injury. A very distinct case of spontaneous bursting of the cranium may be found in Dr J. Hamilton's Cases, p. 17.



should, for the advantage of the mother, be perforated as soon as the os uteri is properly dilated; but until the os uteri is fully opened, no attempt to introduce the perforator can be sanctioned.

But although it be thus laid down as a general rule, that the pelvis, which measures three inches in its conjugate diameter, may admit a living child to pass, either by the application of the vectis or forceps, or still more rarely by the efforts of the womb, yet it is nevertheless true, that sometimes the child must be destroyed, even when the space is fully three inches. This may become necessary, owing to the great size of the child and firmness of the cranium, or a hydrocephalic state of head\*; or the soft parts in the pelvis may swell so much as to diminish, in an increasing ratio, the size of the pelvis, and effectually to obstruct delivery†. The parts may also be so tender, as to render even a common examination painful, and to prevent the application of the vectis or its effective action, in a case merely equivocal. Alarming convulsions may likewise induce us to perforate the head in a case of deformity, where it is perhaps possible that the vectis might succeed, after a greater delay or length of time than is compatible with the safety of the mother; but this combination of evils must be rare. No practitioner, I believe, in this city, has met with such a case. At one period, however, the crochet was employed in cases of convulsions, where the vectis or forceps would now be used.

By the rash and unwarrantable use of the crotchet, living children have been drawn through the pelvis with the skull opened, and have survived in this shocking state for a day or two‡.

To prevent all risk of bringing a living mutilated child to the world, and to avoid, at the same time, killing or giving

\* I have seen a cranium so enlarged with water, that when it was inflated after delivery, so as to resume its former size, it measured twenty-two inches in circumference.

† Baudelocque *l'Art. des Accouch.* § 1705.—See also a Case in point in Dr A. Hamilton's *Letters*, p. 83.—Every attentive practitioner must, from his own experience, admit the fact.

‡ Vide Mauriceau, *obs.* 581.—La Motte, case CXc.—Hamilton's *Letters*, p. 153.—Pou La. *Pratique*, p. 346.—Crantz de *Re Instrument*, &c, § 38.

pain to the child\*, even in those cases which clearly demanded the use of the perforator, some have delayed operating until the child appeared to have been destroyed by the expulsive efforts or other causes, and have therefore been anxious to ascertain the signs by which the death of the child might be known<sup>2</sup>. It was still more desirable to know these, at a time when the forceps were undiscovered. But the signs are generally extremely equivocal, nor is this much to be regretted, for we do not operate because the child is dead, but because it is impossible for the woman to be otherwise delivered.

The steps of the operation are very simple. The rectum, but especially the bladder, being properly emptied, we place the fore finger of one hand on the head of the child, and with the other hand convey the perforator to the spot on which the finger rests. The instrument, being carried cautiously along the finger as a director, can neither injure the vagina nor os uteri, and in general no difficulty is met with in this part of the operation. Sometimes, however, in very great deformity, the os uteri is placed so obliquely, that it must previously be gently brought into the most favourable, that is, the widest part of the pelvis; and afterwards, the perforator, being placed on the head, must have its handle in the axis of the brim, which may require the perinæum to be stretched back. These points being attended to, the scalp is then to be pierced, and the point of the instrument rests on the bone, through which it directly, or after a momentary pause, is to be carried, either by a steady thrust or a boring motion. It is to be continued in, till checked by the stops. The blades are then to be opened, so as to tear up the cranium; and in order to enlarge the opening, they may be closed and turned at right angles to their former position, and again opened, so as to make a crucial aperture. If the liquor amnii have been well evacuated, and a portion of the cranium have entered the pelvis, the perforation can be made without any assistance; but if the whole of the head be above the brim, it may be necessary

\* It has been disputed, whether the child in utero was capable of sensation, but both facts and reasoning are in favour of its sensibility.

to have it kept steady, by pressure above the pubis. It may be proper to add, that if the face present, we must perforate the forehead, just above the nose. If we have turned the child, and wish to open the head, the instrument must be introduced behind the ear.

The brain is next to be broken down, by turning the perforator round within the head. If part of the cranium have entered the pelvis, some of the brain will come out with a squirt, whenever the bones are opened; and at all times we have more or less hemorrhage from the vessels of the brain. Sometimes the blood flows very copiously. The patient is now, if fatigued, to have an anodyne; and at any rate, except in very urgent cases, is to be left for some hours to repose, or to the operation of natural pains. Dr Osborn, in his elaborate essays, advises, that the head should be opened early, and that we should then delay to extract for thirty hours. In cases of great deformity, decidedly requiring the use of the crotchet, the first direction is important; but where there is any possibility of avoiding the perforation, it ought not to be attempted till the event has proved the necessity. The general principle of the second direction is just, where the first has been acted on, and the strength is good, and no urgent symptom is present; but the delay of the specific number of thirty hours is, in most cases, too long; and I question if it be sufficient to produce, in any case where the child was alive when the skull was perforated, such a degree of putrefaction as materially to facilitate the operation. The chief benefit of delay is, to bring as much of the cranium as possible into the pelvis.

If the deformity have been no more than just sufficient to require the use of the perforator, then, if the pains become strong, it is possible for the head to be expelled without farther assistance. But if the deformity be greater, or the pains weak, then only the pliable part of the cranium will descend, and the face and basis of the skull remain above the brim of the pelvis. In this case, the crotchet is to be introduced through the aperture of the cranium, and fixed upon the petrous bone, or such projection of the sphenoid bone, or oc-



ciput, as seems to afford a firm fixture. We then pull gently, to try the hold of the instrument; and this being found secure, we proceed to extract in the direction of the axis of the brim, by steady, cautious, and repeated efforts, exerting, however, as much strength as may be necessary to overcome the difficulty. In doing this, we must always keep a hand, or some of the fingers, in the vagina and on the cranium, to save the soft parts, should the instrument slip. If the force be steadily and cautiously exerted, we may always feel the instrument slipping or tearing the bone, and have warning before it comes away. We should, in extracting, co-operate as much as possible with the pains.

But it sometimes happens, that the pelvis is so small, as to require the head to be broken down, and nothing left but the face and base of the skull. This is an operation which will be greatly facilitated by the putrefaction or softening of the head, which takes place some time after death. If the child be recently dead, the bones adhere pretty firmly, and, in a contracted space, it will require some management to bring them away. But if the parts have become somewhat putrid, or the child been long dead, the parietal and squamous bones come easily away, and the frontal bones separate from the face, bringing their orbitary processes with them. We have then only the face and basis of the skull left, and if the pelvis will allow these remains to pass, then the crotchet can be used. I have carefully measured these parts, placed in different ways, and entirely agree with Dr Hull, a practitioner of great judgment and ability, that the smallest diameter offered, is that which extends from the root of the nose to the chin. For, in my experiments, after the frontal bones were completely removed, this did not in general exceed an inch and an half. It is therefore of great advantage, to convert the case into a face presentation, with the root of the nose directed to the pubis. The size of the crotchet, which ought to be passed over the root of the nose, and fixed on the sphenoid bone, must, however, be added, to this measurement. I never have yet been so unfortunate as to meet with what may be considered as the smallest pelvis,

admitting of delivery *per vias naturales*; \* but I would conclude, that whenever the pelvis, with the soft parts, measures fully an inch and three quarters †, or, if the head be unusually small, the child not being at the full time, an inch and an half, the crotchet may be employed, provided the lateral diameter of the aperture in the pelvis be three inches, or within a fraction of that, perhaps two inches and three quarters, if the head be small or very soft; and the operation will be easy, as we extend the diameter of the pelvis beyond what may be considered as the minimum. It is scarcely necessary to add, that if the outlet be much contracted, it will make the case more unfavourable; and where we have any hesitation, owing to the shape and dimensions of the brim, will determine us against it.

In this manner of operating, the face is drawn down first, and the back part of the occipital bone is thrown flat upon the neck like a tippet. If we reverse this procedure, and bring the occiput first, and the face last, fixing the instrument in the foramen magnum, then, as we have the chin thrown down on the throat, we must have both the neck and face passing at once, or a body equal to two inches and three quarters. If on the other hand, we fix the instrument on the petrous bone, which is certainly preferable to the foramen magnum, and bring the head sideways, we must have both that bone and the vertebræ passing at once, or a substance equal to two inches and a half in diameter; and if the head pass more obliquely, then it is evident that the size must be a little more. Although, therefore, Dr Osburn be correct, in saying, that the base of the cranium, turned sideways, does not measure more than an inch and a half; yet we must not forget, that when the opposite side comes to pass, the neck passes with it, which increases the size.

The head being brought down and delivered, we then fix

\* I cannot learn that any case of extreme deformity in a pregnant woman, such as to render it barely possible to deliver with the crotchet, or necessary to have recourse to the cesarean operation, has occurred in this city since the year 1775, when Mr Whyte performed the latter operation.

† M. Baudeloque considers the crotchet as inadmissible, when the pelvis measures only an inch and two thirds.

a cloth about it, and pull the body through ; or, if this cannot be done, we open the thorax, and fix the erotchet on it, endeavouring to bring down first a shoulder, and then the arm.

In operating with the erotchet, we must always bring the head through the widest part of the pelvis ; but where the deformity is considerable, no small force is requisite. This is productive of pain during the operation, and of danger of inflammation afterwards, which may end in the destruction of some of the soft parts ; or, affecting the peritoneum, it may prove fatal to the patient. From injury done to the bladder, retention of urine may be produced, which if neglected, is attended with great risk. Incontinence of urine is less to be dreaded, as it is sometimes cured by time. Severe pain in the loins and about the hips, with lameness, is another troublesome consequence. If the patient be not affected with malaeosteon, the warm, and at a more advanced period the cold bath, frietion, and time, generally prove successful.

To avoid the destruction of the child, and the severity of the operation of extracting it, the induction of premature labour has been proposed<sup>3</sup>; and the practice is defensible, on the principle of utility as well as of safety. We know that the head of a child, in the beginning of the seventh month, does not measure more than two inches and an half in its lateral diameter ; two and three quarters in the end of that month ; and three in the eighth month. We know farther, that there is no reason to expect that a full grown foetus can be expelled alive, and very seldom, even after a severe labour, dead, through a pelvis whose dimensions are not above two inches and an half : and lastly, we have many instances, where children born in the seventh month have lived to old age. Whenever, then, we have by former experience ascertained beyond a doubt, that the head, at the full time, must be perforated, it is no longer a matter of choice, whether, in succeeding pregnancies, premature labour ought to be induced. It is certainly easier for the mother than the application of the crotchet, and no man can say that it is worse for the child \*. All the principles of morality, as well as of science,

\* It has been proposed, by low diet, to restrain the growth of the child, but this is a very uncertain and precarious practice.



justify the operation; they do more, they demand the operation. The period at which the liquor amnii should be evacuated must depend upon the degree of deformity; and where that is very great, it must be performed at a period so early, as to afford no prospect of the child surviving: it must be done in this case to save the mother, or sometimes it may be requisite to use the lever, even when labour has been prematurely brought on. There are cases, and these cases are not singular, where the bones gradually yield, and become so distorted, as at last to prevent even the crotchet from being used. Now, granting a succession of pregnancies to take place in this situation, it follows as a rule of conduct, that if the deformity be progressive, we should regularly shorten the term of gestation, exciting abortion, even in the third month, if necessity requires it, and treating the case as a case of abortion, enjoining strict rest, and plugging the vagina to save blood. Some may say, Shall we thus, by exciting abortion, destroy many children to save one woman? This objection is more specious than solid. Those who make it would not, in all probability, scruple to employ the crotchet frequently; and where is the difference to the child, whether it be destroyed in the third or in the ninth month? How far it is proper for women in these circumstances to have children, is not a point for our consideration, nor in which we shall be consulted. I would say, that it is not proper; but it is no less evident, that when they are pregnant we must relieve them.

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## CHAP. VII.

### *Of Impracticable Labour.*

It may be urged against the reasoning in the conclusion of the last chapter, that the cæsarean operation ought to be performed; and, doubtless, in cases of extreme deformity, if the proper time for inducing labour be neglected, it must be performed. But the danger is so very great to the mother, that this never can be a matter of choice, but of necessity. In balancing the cæsarean operation against the use of the

crotchet or the induction of abortion, we must form a comparative estimate of the value of the life of the mother and her child. By most men, the life the mother has been considered as of the greatest importance; and therefore, as the cæsarean operation is full of danger to her, no British practitioner will perform it, when delivery can, by the destruction of the child, be procured *per vias naturales*. As, in many instances, the woman labours under a disease found to be hitherto incurable, it may be supposed, that the estimate will rather be formed in favour of the child. But, in the first place, we cannot always be certain that the child is alive, and that the operation is to be successful with respect to it: and, in the second place, it ought to be considered, how far it is allowable, in order to make an attempt to save the child, to perform an operation, which, in the circumstances we are now talking of, must, according to our experience, doom the mother to a fate, for which, perhaps, she is very ill prepared.

There are, I think, histories of twenty cases, where this operation has been performed in Britain; out of these only one woman has been saved\*, but ten children have been preserved. On the continent, however, where the operation is performed more frequently, and often in more favourable circumstances, the number of fatal cases is much less†. If we confine our view to the success of the operation in this island, we must consider it as almost uniformly fatal to the mother. This mortality is owing, not only to the injury done to the cavity of the abdomen, and the consequent risk of inflammation, even under the most favourable circumstances, and with the best management; but also to the morbid condition of the system, at the time when the operation was performed; many of the women being affected with malacosteon, which would in no very long time have of itself proved fatal. From this unfavourable view, it may per-

\* Vide a case by Mr Barlow, in *Med. Records and Researches*, p. 154.

† According to Dr Hull, we had when he published, at home and abroad, records of 231 cases of this operation, 139 of which proved successful. Vide Translation of M. Baudelocque's *Memoir*, p. 233.

haps arise as a question, whether nature, if not interfered with, might not, as in extra-uterine pregnancy, remove by abscess the child from the uterus? It has been said, that this event has taken place; but I do not recollect one satisfactory case upon record. Whenever this has happened, the uterus has either been ruptured, and the child expelled into the cavity of the abdomen; or, in a very great majority of the instances, the child has, evidently from the first, been extra-uterine. We are therefore led to conclude, that the mother who cannot be delivered by the crotchet, must submit to the cæsarean operation, or must inevitably perish, together with the fruit of her womb.

It has been asserted by Dr Osborn, that this operation can seldom if ever be necessary; never where there is the space of an inch and a half from pubis to sacrum, or on either side: and that he himself has, in a case where the widest side of the pelvis was only an inch and three quarters broad, and not more than two inches long, delivered the woman, by breaking down the cranium, and turning the basis of the skull sideways. As the patient recovered, and afterwards, I think, died in the country, where she could not be examined, we cannot say to a certainty what the dimensions of the pelvis were. Dr Osborn must only speak according to the best of his judgment. I have the highest respect for his character and for his works, and nothing but irresistible arguments could make me doubt his accuracy. But from the statement which I have already given of the dimensions of the head, when broken down at the full time, as well as from the experiments of Dr Hull, and the arguments of Dr Alexander Hamilton and Dr Johnson, I am convinced that there must be some mistake in Sherwood's case. Had the child been brought by the face, there might have been room for it to pass, so far as the short diameter of the passage is concerned; but the lateral diameter is too small for the head, if of the usual size, to pass, in that which I consider as the most favourable position. In the cases related by Dr Clarke \*,

\* Vide Dr Osborn's *Essays*, p. 202, and *London Med. Journal*, VII. p. 46.



who is a practitioner of the highest authority, we are informed, that the short diameter of the passage did not exceed an inch and a half, but we are not informed of the lateral extent. As the women both recovered, the precise dimensions and construction of the pelvis cannot be determined. It is likewise much to be regretted, that the diameter of the cranium, or cranium and neck, in the state in which they may have been supposed to come through the passage, was not taken after delivery. Where, and only where, it can be ascertained, that the head placed in the position in which it was drawn through the pelvis, does not form, in any part, a substance measuring more than an inch and a half by two inches or three inches, it is allowable to infer, that the cavity through which it passed may have been as small as that.

Finally, this is a question on which, although we may lay down a general rule, we must admit of some exceptions; for a premature, or a very small child, may be brought through a pelvis which will not permit, by any means, an ordinary sized foetus to pass. But it behoves us, in our reasoning, to judge every child to be at the full time, unless we know the contrary, and to make an estimate on the average magnitude; and until the contrary is proved, by dissection of the mother, or careful and rigid measurement of the child after delivery, I must hold to the position formerly laid down, that the crotchet cannot be used when the child is of the full size, unless we have a passage through the pelvis, measuring fully an inch and three quarters in the short diameter, and three inches in length, or, if the child be premature and soft, an inch and a half broad, and two inches and three quarters long<sup>1</sup>.

The operation itself, although dangerous in its consequences, and formidable in its appearance, is by no means difficult to perform. Some advise the incision to be made perpendicularly in the linea alba, others transversely in the direction of the fibres of the transversalis muscle. Perhaps the precise situation and direction of the wound must be regulated by the circumstances of the case, and the shape of the abdomen; but in general, I apprehend, that the transverse wound

will be most eligible. The length of the incision, through the skin and muscles, ought to be about six inches; and if a vessel bleed, so as to require the ligature, it will be proper to take it up before proceeding farther. The uterus is next to be opened, by a corresponding incision; and as the fundus, owing to the pendulous shape of the abdomen, is the most prominent part, the incision will in general be made there, unless the external wound be made lower than usual. The child is next to be extracted, and immediately afterward the placenta. One assistant is to take the management of the child, whilst another takes care to prevent the protrusion of the bowels. In this part of the operation, although pretty large vessels are divided, yet the hemorrhage is seldom great; it has, however, proved fatal. The external wound is now to be cleaned, its sides brought together, and kept in contact by a sufficient number of stitches passed through the skin alone, or the skin and muscles, avoiding the peritoneum. Adhesive plasters are to be placed carefully in the intervals; and a bandage, with a soft compress, being applied, the patient is to be laid to rest. An anodyne should be given, to diminish the shock to the system; and our future practice must, upon the general principles of surgery, be directed to the prevention or removal of abdominal irritation and inflammation. The patient may die, although there be very little inflammation of the peritoneum. It has been proposed by Dr Hull, to whose work I refer for more particular information, to operate as soon as the os uteri is dilated, and before the membranes burst, in order that the wound of the uterus may contract into a smaller size.

In order to supersede the cæsarean operation, and even to avoid the use of the crotchet, it was many years ago proposed to divide the symphysis pubis, in expectation of thus increasing the capacity of the pelvis. This proposal was founded on an opinion, that the bones of the pelvis, either always or frequently, did spontaneously separate, or their joinings relax, during gestation and parturition, in order to make the delivery more easy. In deformity of the pelvis,

the symphysis was first divided by a knife during labour, by M. Sigault, in 1777, assisted by the ingenious M. Alphonse Le Roy. The operation was afterwards repeated on the continent, with various effects, according to the degree of deformity and extent of the separation. It has only once\* been adopted in this country, because it is not only dangerous in itself to the mother, but also of limited benefit to the child. We have already seen, that there is a certain degree of deformity of the pelvis, which will prevent a child at the full time, and of the average size, from passing alive, or with the head entire. Now, in a case, where it is barely impracticable to use the lever or forceps, and where it just becomes necessary to open the head, the division may perhaps save the child, and with less danger to the mother than would result from the cæsarean operation, which is the only other chance of saving the infant. If we increase the contraction of the pelvis beyond this degree, then the chance of saving the child is greatly diminished; and the extent to which the bones must be separated to accomplish delivery, would, in all probability, be attended with fatal effects. In such a case, the crotchet can be employed with safety to the mother, and continues to be eligible, until we find the space so small as to require the cæsarean operation; and in this case, the division can do no good. It cannot even make the crotchet eligible, owing to the shape of the pelvis in malacosteon, and the great mischief which would be done to the parts after the division, by the necessary steps of the instrumental delivery. There is only one degree of disproportion, then, betwixt the head and the pelvis, which will admit of the division, but the smallest deviation from this destroys the advantage of the operation. Now, as this disproportion is so nice, we cannot in practice ascertain it; for although we could determine, within a hundredth part of an inch, the capacity of the pelvis, yet we cannot determine the precise dimensions of the head, and thus establish the relation of the two. On this account, the division of the symphysis

\* Vide case by Mr Whelchman, in Lond. Med. Journal for 1790, p. 46.



pubis cannot be adopted with advantage, either to the mother or child.

## CHAP. VIII.

### *Of Complicated Labour.*

#### ORDER FIRST.

DURING labour, there is always a slight discharge of bloody slime, when the membranes begin to protrude; for the small vessels of the decidua, near the cervix uteri, are opened. In some cases, a very considerable quantity of watery fluid, tinged with blood, flows from the womb, but this is attended with no inconvenience. It may happen, however, that pure blood is discharged, and that in no small quantity. If this take place in the commencement of labour, it differs in nothing from those hemorrhages which I have formerly considered. But occasionally the flooding does not begin, till the first stage of labour be nearly or altogether completed. If the membranes be still entire, it proceeds certainly from the detachment of part of the placenta or decidua, and often is connected with unusual distension of the uterus, from excessive quantity of liquor amnii, or with ossification of the placenta. If the membranes have broken, then we must consider the possibility of its proceeding from rupture of the uterus, and must inquire into the attending symptoms. Sometimes it will be found to proceed from tedious and exhausting labour, from improper exertion, or rude attempts to dilate the os uteri, or alter the presentation; or it may be caused by rupture of the umbilical cord. Now, in this order of labours, the practice is very simple, and admits of little difference of opinion. For every experienced practitioner must admit, that when the hemorrhage is considerable, and is increasing or continuing, the only safety consists in emptying the uterus. If the pains be smart, frequent, and effective, the labour advancing regularly, and there be reason to suppose that it will be finished

before the hemorrhage have continued so long as to produce injurious effects, we may safely trust to nature. We must keep the patient very cool, and in a state of perfect rest. But if the pains be weak, ineffective and rather declining than increasing, whilst the hemorrhage is rather increasing than diminishing, we must deliver the woman, either by turning the child, or applying instruments, according to the circumstances of the case, and the situation of the head.

#### ORDER SECOND.

When hemorrhage takes place from the lungs or stomach during parturition, we ought to have recourse, in the first place, to blood-letting, or such other means as we would employ were the patient not in labour. If the hemorrhage continue violent, or be increased by the pains of parturition, we must consider, whether artificial delivery, or a continuance of the natural process, will be attended with least exertion and irritation, and consequently with least danger; and we must act accordingly.

#### ORDER THIRD.

Syncope may proceed from various causes, such as hemorrhage, or rupture of the uterus; but these cases have been already, or will be considered. It may proceed from a delicate nervous constitution, from long continued labour, from particular states of the heart or stomach, and from passions of the mind. A simple paroxysm of fainting, unless it proceed from causes which would otherwise incline us to deliver, such as tedious labour, flooding, &c. is not to be considered as a reason for delivering the woman. We are to employ the usual remedies, and particularly keep the person in a recumbent posture. Ammoniated tincture of valerian or tincture of opium are useful. But if the paroxysms be repeated, whatever their cause may be, we ought to deliver the woman, if the state of the os uteri will permit. We must be very careful to prevent hemorrhage, after the expulsion of the child.

## ORDER FOURTH.

Convulsions may occur, either during pregnancy or labour, and are of different kinds, requiring opposite treatment. One species is the consequence of great exhaustion, from excessive fatigue, tedious labour, or profuse hemorrhage. This makes its attack without much warning, and generally alternates with delirium, or great feeling of depression and debility; the muscles about the face and chest are chiefly affected, and the pulse is small, compressible, and frequent, the face pale, the eye sunk, the extremities cold. The fits succeed each other pretty quickly, and very soon terminate in a fatal syncope. This species naturally requires that we should, first of all, check the farther operation of the exciting cause, by restraining hemorrhage, or preventing every kind of exertion, and then husband the strength which remains, or recruit it by cordials. Opiates are of great service. Delivery is usually necessary.

Hysterical convulsions are more common during gestation, than during labour. They are distinguished, by being preceded by a timid state of mind, and attacking pretty suddenly; there is evident appearance of globus or struggling about the throat. There is no foaming at the mouth, no working with the tongue, and indeed very little distortion of any of the muscles about the face. The person also sometimes utters, during the fit, a kind of crowing noise; and when she recovers, she is generally, but not always sensible of having been ill. Occasionally there is a tendency to faint, although there have been little exhaustion. The face is pale; and the patient can usually be so far roused, during the fit, as to look up, or answer in a monosyllable, or swallow a little drink. Rest and antispasmodics are indicated; but if the fit continue, or is renewed, venesection will be proper. In some cases the patient soon recovers without any remedy, and has no return of the complaint.

The most frequent species of puerperal convulsions, however, is of the epileptic kind, which occurs fifty times for



once that the others appear. Convulsions may affect the patient suddenly, and severely. She rises to go to stool, and falls down convulsed; or, sitting in her chair, conversing with her attendants, her countenance suddenly alters, and she is seized with a fit; or, she has been lying in a sleep, and the nurse is all at once alarmed by the shaking of the bed, and the strong agitation of her patient. Immediately all is confusion and dismay, and the screams of the females announce that something very terrible has happened. Presently the convulsion ends in a short stupor, from which the woman awakes, unconscious of having been ill; and thus, for a time, the apprehensions of the attendants are calmed. But in a short time the same scene is generally repeated; or, perhaps, although the convulsion has gone off, the stupor remains. It is, however, not unusual for the fit to be preceded by some symptoms, which, to an attentive observer, indicate its approach. These may even exist to a degree which cannot be neglected. They are, head-ache, which is sometimes dreadful; or acute pain in the stomach, with unsupportable sickness; ringing in the ears; dazzling of the eyes, or appearance of substances floating before them, either opaque, or, more frequently, of a fiery brightness. The pulse is slow, the patient sometimes sighs deeply, or has violent rigors, which, in the second stage of labour, are always hazardous. There is great drowsiness during the pains. It is neither uncommon nor dangerous for the woman to be drowsy between the pains; but here, even during them, she falls into a deep sleep. When the attack comes on, which very often is soon after these preludes appear, the muscles are most violently convulsed, the whole frame shakes strongly, and the face is dreadfully distorted\*, and often swollen. The tongue is much agitated, and is very apt to be greatly injured by the teeth; foam issues from the mouth, and the convulsive inspiration often draws this in with a "hissing noise;" or she snores deeply, and cannot be

\* Mr Fynney gives a case, where the lower jaw was luxated during convulsions, which came on in the birth of a second child, or twin. *Med. Comment.* Vol. IX. p. 380.

roused during the fit. The skin becomes, during the convulsion, livid or purple. This attack may end at once in fatal apoplexy, but generally the patient recovers, and is quite insensible of having been ill. Soon, however, the fits are renewed; and if they do not prove fatal, or are not averted by art, they recur with the regularity of labour pains, becoming more and more frequent as they continue. The woman appears to have no labour pains, yet the os uteri is affected, and sometimes the child is expelled. The fit may last only a few seconds, or may continue with very little remission for half an hour.

Apoplexy may take place at the commencement of labour, or during gestation, without convulsions. In the latter case, the os uteri is rarely affected; but in a few instances it has been found dilated, if death did not take place instantaneously. Copious blood-letting is the principal remedy in this case.

Convulsions may occur in any period of labour, or before it has begun, or after the delivery of the child; and in this last case, are sometimes preceded by great sickness or oppression at the stomach. Dr Leak relates the case of a patient who had ten or eleven of these fits; the abdomen was swelled and tense, and she vomited phlegm mixed with blood, which probably came from the tongue. She recovered by means of blood-letting and clysters.

Puerperal convulsions seem to be different from common epilepsy, for they recur at no future time, except perhaps in a subsequent pregnancy. They take place in greater number in a given time, than epilepsy does in general. They often recur exactly like labour pains, or are frequently accompanied or preceded by them; though when the convulsion comes on, the feeling of pain is suspended, and often, though not always, the uterine contraction is stopt or diminished. The same observation applies to excessive rigors, which are, indeed, a species of convulsions, but are not attended with distortion of the face nor insensibility. If the patient be in a state of stupor, she frequently has the countenance distorted at intervals, accompanied with some uter-



rine action. They are preceded by different symptoms, and never by aura; and the patient usually recovers sensibility much sooner, and more completely during the intervals, than in epilepsy. The organs of sense, particularly the ear, are often preternaturally sensible. Sometimes the child is unexpectedly born during a fit.

Convulsions, of the kind I am considering, evidently are connected with gestation or parturition; they occur at no other time, and are more frequent in a first labour. I shall not enter into the theory, but state the practice, which is of more consequence. The first object is, to prevent the patient from injuring the tongue, by inserting a piece of wood into the mouth; this occupies no time. Next, we bleed the patient, and, if the circumstances of the case will permit, we should open the jugular vein. We must not spare the lancet. All our best practitioners are agreed in this, whatever their sentiments may be with regard to the nature of the disease, or to other circumstances. We must bleed once and again, whether the convulsion occur during gestation or pregnancy\*. There is more danger from taking too little blood, than from copious evacuation. Often in a short time, several pounds of blood have been taken away with ultimate advantage. Blood-letting also tends to relax the os uteri. Next, we administer a smart clyster. The head is then to be shaved and blistered; a blister is proper, though the fit have gone off. A smart dose of calomel, or solution of salts, may also be given with advantage, when the person can swallow, especially if the convulsions have occurred during pregnancy, with little tendency to labour. We must also attend to the bladder, that it be emptied, for its distention alone has sometimes brought on convulsions†.

\* La Motte mentions a case, 225, where a woman, in the last five months of pregnancy, was bled eighty-six times. Sometimes 2 oz. would relieve her.—By modern practitioners, from 40 to 80 oz. have been taken with advantage, in a case of puerperal convulsions. Puzos insists on the necessity of copious blood-letting and speedy delivery. This practice is adopted by the most judicious of the present day.

† La Motte, 223, 224.—Leak relates a case, where it produced *substituta* *menstruum*, and excessive pain at the pubis. Vol. II, p. 344.



One part of the practice, then, and a most important and essential one, too, consists in depletion, by which the risk of fatal oppression of the brain or extravasation of blood within the skull is diminished, and the convulsion mitigated. But this is not all; for the patient is suffering from a disease connected with the state of the uterus, and the state is got rid of by terminating the labour. Even when convulsions take place very early in labour, the os uteri is generally opened to a certain degree, and the detraction of blood, which has been resorted to on the first attack of the disease, renders the os uteri usually lax and dilatable. In this case, although we have no distinct labour pains, we must introduce the hand, and slowly dilate it, and deliver the child. I entirely agree with those who are against forcibly opening the os uteri<sup>1</sup>; but I also agree with those who advise the woman to be delivered as soon as we possibly can do it without violence<sup>2</sup>. There is, I am convinced, no rule of practice more plain or beneficial\*. Delivery does not, indeed, always save the patient, or even prevent the recurrence of the fits, but it does not thence follow that it ought not to be adopted.

Internal remedies have been advised, such as opium, and musk, and camphor; but experience does not establish their utility when trusted to alone; nay, where there is fulness of the vessels, the first of these medicines does harm.

If the fits have been only apprehended, but have not taken place, then we may use remedies as preventives. The most beneficial treatment is, to empty the vessels and the bowels. When there are evident symptoms of disordered stomach, a gentle emetic has been advised; but I have never seen it administered myself, and am, from its effects on the head, not partial to its exhibition. When a violent pain in the stomach takes place, we should bleed and give an opiate. I wish it to be carefully remembered, that when we have head-ach, or any other symptoms indicating a tendency to

\* Even evacuating the liquor amnii has, M. Baudelocque admits, been of service, § 1109, 1111. In one case, the os uteri was hard and callous, it was divided, the child speedily born, and the woman immediately became calm, 1112.

convulsions; the lancet is necessary. Blood-letting can seldom do harm, it may do much good; and if this book serve only to impress this fact on the mind of one reader, I will not regret having written it.

When symptoms of nervous irritation exist, without any determination to the head or fulness of vessels, then, after bleeding, opiates may be of advantage\*. Camphor has been strongly recommended by Dr Hamilton, as the most powerful internal remedy which can be prescribed; but I cannot, from my own observation, say much respecting its virtues as a preventive. But when convulsions have continued after delivery, or when the recovery was not complete, I have found it of service, and recommend it to be always tried *\* vide page 50 of Preface.*

#### ORDER FIFTH.

The uterus may be lacerated during labour, under different circumstances, and from various causes. Any part of it may be torn, but generally the rupture takes place in the cervix, and the wound is transverse. Sometimes the uterus is entire, and the vagina alone is torn. This may happen during any stage of labour, and even before the membranes burst †, but this is uncommon. It may take place when the head has fully entered the pelvis, or in the moment when the child is delivered‡.

The uterus may be ruptured, by attempts rashly made to turn the child †; or after the water has been long evacuated, some projecting part of the child may so effect a portion of the uterus, as to make it tear. A certain set of fibres may also be suddenly and spasmodically contracted, and laceration may thus take place. In these cases, there is often very little warning, and the accident may happen when we are just in expectation of a happy termination of the labour. In

\* Opiates have been strongly recommended by some practitioners, particularly Dr Bland. Jour. Vol. II. p. 328, &c.—Dr Hamilton as strongly prohibits them. Annals of Med. Vol. V.—Petit says, they kill both the mother and the child.

† Vide Mem. of Med. Soc. Vol. II. p. 118.

‡ A fatal case of this kind is related to Mr Dease.—One more fortunate in the issue, is inserted in Mem. of Med. Soc. Vol. IV. p. 253.



a case detailed by Dr Douglass, (p. 50.) the head of the child was resting on the perinæum, when the lady, who had been subject to cramp, uttered a violent cry, and the head receded. The child was delivered, but the patient died. Mr Goldson's patient, complained of cramp in the leg, in the intervals of the labour pains; and in the instant when the rupture happened, she exclaimed "The cramp!" Dr Monro's patient, (Works, p. 677.) was sitting in a chair, when she suddenly screamed, and the uterus was lacerated; she was not delivered, but lived from Tuesday till Friday. Rigidity of the os uteri may also be a cause of laceration\*. It dilates very slowly, requires great exertion of the uterine fibres, and the patient suffers much pain. The uterus may at last be torn, even although the head has partly descended into the pelvis, and the pelvis be large. In this case the liquor amnii is usually discharged before the rupture takes place. The most frequent cause, however, of this accident, is a disproportion between the size of the head and the capacity of the pelvis; by which a portion of the cervix uteri is pinched between the head and the pelvis, and fixed so, that the action of the uterus is directed against this spot, rather than the os uteri. The woman feels very severe pain, either in the back or at the pubis, which, during the action of the uterus, augments to an extraordinary degree, and then the part gives way. Another way in which the cervix may be lacerated, is by the linea iliopectinea being so sharp†, that when the uterus is pressed against it, the parts are either cut through, or so much acted on, that they are in a manner killed, and give way, having a sphacelated appearance. In some cases the rectum, but much more frequently the bladder, is opened.

Now, from this view we learn, that those women are most liable to rupture of the uterus, who are very irritable, and subject to cramp; or who have the pelvis contracted, or its brim very sharp; or who have the os uteri very rigid, or any part of the womb indurated. Scholzius relates a case, where

\* Perfect's Cases, Vol. II. p. 439.—Hamilton's Cases, p. 138.

† In a case of this kind, the line was on one side, as sharp as a fruit knife, and a cartilaginous knob projected from the symphysis. The bladder was torn.



it was produced by scirrhus of the fundus ; and Friedius one, where it was owing to a carneo-cartilaginous state of the os uteri. Sometimes the uterus seems to be predisposed to this accident, by a fall or bruise. Reidlinus relates one instance of this. Behling, Steidele, and Perfect, furnish us each with another. Salmuthus considers a thinness of the uterus as a predisposing cause of rupture ; and Dr Ross\* relates a case where it seemed to have this effect, the womb not being above the eighth part of an inch thick, and tearing like paper.

We are led to anticipate laceration, when the patient is restless, and complains of very severe local pain, subject to great exacerbation, and attended with a very acute or tearing sensation. The pains are both violent and frequent, and usually do not produce a great effect on the os uteri, which is often very rigid. These symptoms are still more alarming, if the liquor amnii have been fully evacuated. In such cases, it is necessary to detract blood, which relaxes the parts, and then, if the symptoms still continue, to suspend for a time ; the pains by an anodyne clyster. When this accident does happen the woman feels something give way within her, and usually suffers, at that time, an increase of the pain. The presentation disappears more or less speedily, unless the head have fully entered the pelvis, or the uterus contract spasmodically on part of the child, as happened in Behling's patient†. The pains go off as soon as the child passes through the rent into the abdomen ; or if the presentation be fixed in the pelvis, they become irregular, and gradually decline. The passage of the child into the abdominal cavity is attended with a sensation of strong motion of the belly, and is sometimes productive of convulsions. The shape of the child can be felt pretty distinctly through the abdominal coverings.

The patient, after this accident, soon begins to vomit a dark coloured fluid, the countenance becomes ghastly, the pulse small and feeble, the breathing is oppressed, and frequently the patient cannot lie down. Sometimes the intestine protrudes through the wound in the uterus, and has even

\* Annals of Med. Vol. III. p. 277.

† Haller's Disput. Tom. III. p. 477.

been strangulated in it. These symptoms do not all appear in every case, nor come on always with the same rapidity. In Dr Ross's patient, although the child escaped through a rent in the vagina into the cavity of the abdomen, and though the nature of the case was ascertained, yet no hemorrhage, fainting, nor bad symptoms, took place; and the child being delivered, the woman recovered.

If the patient be not speedily relieved, she becomes very restless, tosses in the bed, and vomits frequently; complains of pain in the belly, which becomes swelled, the pulse is rapid, the extremities become cold, and the strength sinks. In every case that I have seen, the intestines were chiefly affected, being much inflamed. The interval which elapses between the accident and death, is various; but generally, whether the patient be delivered or not, she dies within twenty-four hours, often in a much shorter time. Steidele, however, relates a case, where the patient lived till the twelfth day; Dr Garthshore's patient lived till the twenty-sixth day; and in the Coll. Soc. Havn. Vol. II. p. 326, there is the case of a woman, who, after being delivered, lingered for three months.

Different opinions have been held respecting the best mode of treatment. Some have advised the performance of the cæsarean operation, some delivering *per vias naturales*, and others leaving the case to nature. We have instances of all these methods being successful; but the delivery, by turning the child, has advantages over the other modes, and certainly ought with scarcely any exception to be resorted to. When the os uteri is dilated before the accident takes place, as is usually the case, and the hand can, without much difficulty be introduced, it is to be passed through the os uteri, and the rent in the uterus, into the abdominal cavity, in search of the child's feet, which are to be brought down, and the case managed in the same way as in presentation of the feet. When the placenta is extracted, we are to introduce the hand again, to ascertain that no part of the intestines have protruded through the wound. This process is

always easy, when the rent is in the cervix uteri or the vagina.

But when the os uteri is rigid and very little dilated before the accident happens, and cannot be opened without extreme irritation, which is, indeed, not often the case, and is rather a state which may be supposed, than actually met with; or when the uterus is spasmodically and violently contracted between the rent and the os uteri, which may happen, if the fundus be lacerated; I am inclined to join with those, who consider attempts to deliver as adding to the danger. These cases, if they ever occur, must do so very rarely; but it may happen that deformity of the pelvis prevents delivery. In such circumstances, we must either perform the cæsarean operation, or leave the case to nature. If we have been called early, when the child is yet alive, and before the abdominal viscera have been much irritated by the presence of the fœtus, we are warranted to extract the child by a small incision<sup>4</sup>. If some time, however, have elapsed, then such irritation is often given, as renders it doubtful, if the additional injury of the operation could be sustained. On the other hand, if little irritation be given, and the woman is tolerably well, there is room to hope, that a natural cure may be accomplished, as in extra-uterine pregnancy; and therefore, as the child cannot be saved now, it may be more prudent to trust to nature<sup>5</sup>.

The cases which admit most easily of delivery, are those where the rent is situated in the cervix uteri or vagina; and laceration of the vagina is less dangerous than rupture of the uterus<sup>6</sup>, provided the bladder be not injured. I do not think it necessary to make any farther remarks on the laceration of the vagina, as distinct from that of the womb.

When the head is engaged in the pelvis, and cannot recede after the womb is torn, we have other symptoms, indicating rupture of the uterus, or at least the necessity of using instruments. The strength sinks, the pains become useless or go off, the patient vomits, &c.

When, from precursory symptoms, we expect that laceration is about to take place, we must accelerate labour



either by turning, or the use of instruments, according to circumstances. This is more necessary if the patient has formerly had the uterus torn.

#### ORDER SIXTH.

Suppression of urine may take place during labour, in consequence of the head of the child being locked in the pelvis; or from a kind of paralytic state of the bladder, produced by long retention of the urine; or by a small stone, or quantity of mucus, obstructing the urethra. It produces tenderness, and great pain, in the hypogastric region, which is also swelled. The pain is constant, but is increased during every effort of the abdominal muscles to bear down, because then the bladder is pressed. It is injurious in so far as it tends to impair the uterine action, and it is dangerous on account of the risk of the distended bladder being ruptured by the contraction of the abdominal muscles, or its giving way by a gangrenous rent. The bad symptoms consequent to this event do not always come on instantaneously, and sometimes the bladder still retains a little urine. In a case related by Mr Hey, in the fourth volume of *Medical Observations and Inquiries*, they did not take place till the second day. The patient was thirsty, vomited, had a frequent desire to void the urine, which she did very suddenly, but not more than a tea cup full at once. The pulse was quick, the belly swelled, and pressure gave her pain. She died about the eighth day, and the bladder was found to be ruptured at its upper part.

When the urine cannot be passed by the voluntary efforts of the woman, aided sometimes by pressing up the head of the child, the catheter must be introduced. The perforations of the instrument, however, ought to be large, as a slimy tough mucus in the urethra, sometimes fills completely the orifice of the ordinary size. If the head should be so jammed in the pelvis, as to prevent the introduction of the catheter, the woman must be delivered.

In some cases, although no water is made for a long time, yet no inconvenience is felt; and when the catheter is intro-

duced, very little water is evacuated. This depends upon a diminished secretion; and although, of itself it cannot determine us to accelerate delivery, yet, should it be attended with other bad symptoms in tedious labour, it may form an additional argument for interfering, as then the functions are becoming impaired, and effusion may take place into some of the cavities.

## BOOK III.

### Of the Puerperal State.

#### CHAP. I.

##### *Of the Treatment after Delivery.*

IMMEDIATELY after the placenta is expelled, the finger ought to be introduced into the vagina, to ascertain that the perinæum or recto-vaginal septum be not torn, and that the uterus be not inverted.

Then, if the woman be not much fatigued, she is to turn slowly on her back, and a broad bandage is to be slipped under her, which is to be spread evenly, and pinned so tightly round the abdomen, as to give a feeling of agreeable support. This bandage is made of linen or cotton cloth; and it is usual to place a compress over the uterus, but this is not essential. The wet sheet is also to be pulled from below her, and an open flannel petticoat is to be put on; it has a broad top band, and is introduced and pinned like the bandage. A warm napkin is then to be applied to the vulva, and the woman laid in an easy posture, having just so many bed-clothes as make her comfortable. If she desire it, she may now have a little panado, after which we leave her to rest. But before retiring, it is proper to ascertain that the bandage be felt agreeably tight, that there be no considerable he-

hemorrhage, and that the after-pains are not coming on severely. It is also proper to mark the state of the pulse, and to leave strict directions with the nurse, that every exertion, and all stimulants be avoided.

Having thus simply stated what appears to be necessary, I must next say what ought to be avoided. It is customary with many nurses, to shift the patient completely, and, for this purpose, to raise her to an erect posture. Now this practice may not always be followed by bad consequences, but it is very reprehensible; for the patient is thus much fatigued, and if she sit up even for a short time, hemorrhage or syncope may be produced. The pretext for this is generally to make the woman comfortable; and, indeed, if the cloaths be wet with perspiration or discharge, there may be some inducement to shift her. But this ought to be done slowly, without raising her, and if she have been fatigued, not until she have rested for a little. Another bad practice is, the administration of stimulants, such as brandy, wine, or cordial waters. I do not deny, that these, in certain cases of exhaustion, are salutary; but I certainly maintain, that generally they are both unnecessary and hurtful, tending to prevent sleep, to promote hemorrhage, and excite fever. A third practice, no less injurious, is, keeping the room warm with a fire, drawing the bed-curtains close, increasing the bed-clothes, and giving every thing warm to promote perspiration. This is apt to produce debility, and many hysterical affections, as well as a troublesome species of fever, which it is often difficult to remove. It also renders the woman very susceptible of cold, and a shivering fit is very readily excited. Lastly, gossiping and noise of every kind, is hurtful, by preventing rest, occasioning head-ach or palpitation, as well as other bad symptoms.

At our next visit, which ought to be within twelve hours after delivery, we should inquire whether the patient have slept, and ascertain that the pulse be not frequent, that the after-pains have not been severe, nor the discharge copious. We should also particularly inquire if she have made water; and if she have not, but have a desire to do so without the



power, a cloth dipped in warm water, and wrung pretty dry, should be applied to the pubis. If this fail, the urine will often be voided if the uterus be gently raised a little with the finger, or the catheter may be introduced. There are two states in which we are very solicitous that the urine be voided: the first is, when the woman has much pain in the lower belly, with a desire to void urine; the second is, after severe or instrumental labour.

A stool should be procured within twenty-four or thirty-six hours after delivery, either by means of a clyster or a gentle laxative. If the patient usually have the milk-fever smartly, or the breasts are disposed to be painful and tense, a mild dose of some saline laxative is better than a clyster. But if she be delicate, and have formerly had little milk, a clyster is to be preferred. If she is not to suckle the child, then the laxative should be rather brisker, and may be repeated at the interval of two days.

After delivery, there is a discharge of sanguineous fluid from the uterus for some days, which then becomes greenish, and lastly pale, and decreases in quantity, disappearing altogether within a month, and often in a shorter time. This is called the lochial discharge. During this time, it is necessary that the vagina and external parts be daily washed with tepid milk and water.

During the latter end of gestation, milk is generally secreted in a small quantity in the breasts, and sometimes it even runs from the nipples. After delivery the secretion increases, and about the third day the breasts will be found considerably distended. Many women, indeed, complain at this time of much tension and uneasiness, and there is usually some acceleration of the pulse. A pretty smart fever may even be induced, which is called the milk fever. The best way to prevent these symptoms from becoming troublesome, is to keep the bowels open, and apply the child to the breasts before they have become distended. This may generally be done twelve hours after delivery.

The diet of women in the puerperal state ought to be light; and if they are not to give suck, liquids should be a-

voided, the food must be of the dry kind, and thirst should be quenched, rather with fruit than with drink. If they are to nurse, the diet, for the first two days, should consist of tea and cold toasted bread for breakfast, beef or chicken soup for dinner, and panado for supper; toast water, or barley water, may be given for drink, but malt liquor should be avoided. Unless the patient be feeble, and at the same time have no fever, wine should not be allowed for the first two days; a little may then be added to the panado or sago, which is taken for supper; and a small glass, diluted with water, may be taken after dinner. A bit of chicken may be given for dinner, and in proportion as recovery goes on, the usual diet is to be returned to.

The time at which the patient should be allowed to rise a little, to have the bed made, must be regulated by her strength, and other circumstances. It ought never to be earlier than the third day, and, in a day or two longer, she may be allowed to be dressed, and sit a little; but even in the best recovery, and during summer, the woman ought not to leave her room within a week. She ought not to go out for an airing, in general, till the third week. In cold weather, and when the patient is delicate, she must be longer confined. By rising too soon, and making exertion, a prolapsus uteri may be occasioned, and still more frequently the lochia are rendered profuse, and the strength impaired.

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## CHAP. II.

### *Of Uterine Hemorrhage.*

IN natural labour, after the expulsion of the child, the uterus contracts so much as to loosen the attachment of the placenta and membranes to its surface, and afterwards to expel them. This process is always accompanied by the discharge of blood, but the quantity in general is small. If, however, the uterine fibres should not duly contract after the delivery of the child, so as to diminish the diameter of the vessels, and at the same time accommodate the size of

the womb to the substance which still remains within it; then, provided the placenta and membranes be wholly or in part separated, the vessels which passed from the uterus to the ovum, will be open and unsupported, and will pour out blood with an impetuosity proportioned to their size and the force of the circulation. This flow will continue until syncope checks the motion, or coagula stop the mouths, of the vessels.

It is evident that the cause of flooding is the torpor of the uterus \*. The fibres may become inactive, or have their tonic contraction impaired immediately after the pain which expels the child. This will more especially happen if the woman be weakly, if the labour have been tedious, and the child at last expelled suddenly by a strong, but perhaps only momentary contraction.

The hemorrhage, therefore, appears very soon after delivery, and before the placenta has come away. It is profuse, and produces the usual effects of hemorrhage on the system, and these effects are greater and more speedy than those which follow from hemorrhage before delivery, for the loss is instant and extensive. The first gush indeed does not produce great debility, because it consists chiefly of blood, which formerly circulated in the uterus, and is not taken directly from the general system; and the separation of the placenta not being wholly effected at once, the loss at first is more slow. But immediately after this, the effect appears in all its danger; and it is not unusual for the woman, if not assisted, to die within ten minutes after the birth of the child †.

\* When the uterus contracts properly after the delivery of the child, it will be felt, if the hand be applied on the abdomen, like a hard and strong mass: but when torpid, it is not so distinctly felt, for it is softer, being destitute of tonic contraction.

† The patient may die speedily after the birth of the child, in consequence of other causes, some of which it may not be improper to notice. Sudden death may proceed from an organic affection of the heart, such as ossification of the valves or arteries, dilation of the cavities of the heart, or aneurism of the aorta. The effect of any sudden change in the system, in these cases, must be known to every practitioner. Whenever we suspect such disease, the most perfect rest must be observed after delivery. Should there be any inequality in the size of the two ventricles, the right being larger, for instance, than the left, then any cause capable of hurrying the circulation, may make



If flooding occur after delivery, the woman says there is surely an unusual discharge; and, on examining, it is found to be really so; but at first the pulse is pretty good, and the countenance is not much altered. In a minute, perhaps, the pulse sinks, the face becomes pale, the hands cold, the respiration is performed with a sigh, or after lying quiet for a little, a long sigh is fetched, and the patient seems as if trying to awake from a slumber. She exclaims she is sick, and immediately vomits, she throws out her arms, turns off the bed-clothes, and seems anxious for breath; she complains of cold, or perhaps is restless, and begs not to be disturbed; or lies in a state approaching to syncope, or gazes wildly around her, and is extremely restless, breathes with difficulty, and quickly expires. The danger of flooding is universally known, and the consternation excited by it, is in many cases great: One exclaims the patient is dead, another she is dying, one is wringing her hands, another running for cordials, and it requires no small steadiness and composure in the practitioner to prevent mischievous interference, or procure necessary aid.

The torpor of the uterus is sometimes so great and universal, that when the hand is introduced, it passes almost up to the stomach. At other times, a circular band of fibres contracts spasmodically about the middle of the uterus, inclosing the placenta above it, whilst the rest of the fibres become relaxed. This has not inaptly been called the hour-glass uterus.

From this view it is evident, that flooding is to be prevented by preserving the action of the uterus, and avoiding whatever can increase the force of the circulation. A powerful means of keeping up the action of the womb, consists in preventing it from emptying itself too suddenly. It too frequently happens, when the child is instantaneously expelled by a single contraction, being in a manner projected

both sides contract to their utmost; the consequence of which is, that all the blood in the right side is thrown out, but it cannot be received into the left; rupture of the pulmonary vessels must take place, and I have known many instances where the patient was immediately suffocated:

from the uterus, or when the body is speedily pulled out, whenever the head is born, that hemorrhage takes place; and, in a majority of instances, the uterus contracts on the placenta like an hour-glass. Delivery then is not to be hurried, the steps of expulsion should be gradual; instead of pulling out the body of the child, we should rather retard the expulsion when it is likely to take place rapidly. Those who estimate the dexterity and skill of an accoucheur by the velocity with which he delivers the infant, ground their good opinion upon a most dangerous and reprehensible conduct; and he who adopts this practice, must meet with many untoward accidents, and produce many calamities.

Another mean of exciting the uterine action, is by supporting the abdomen, and making gentle pressure on it with the hand immediately after delivery. I do not say that this practice is in every instance necessary; but it is so generally useful, that it never ought to be omitted. The circulation is also to be moderated by the free admission of cool air, by lessening the quantity of bed-clothes, by a state of perfect rest, and by avoiding the exhibition of stimulants. If these directions, which are few and simple, be attended to, we shall seldom meet with hemorrhage after the delivery of the child. Some women, no doubt, are peculiarly subject to this accident. They are generally of a lax fibre, easily fatigued and fluttered, and subject to hysterical affections. When a woman is known to be subject to hemorrhage, we should give her a full dose of laudanum immediately after delivery, and, on the first appearance of discharge, perhaps in some instances whenever the child is born, we ought to introduce the hand into the uterus, which excites its action, and prevents flooding. We are not to meddle with the placenta, or endeavour to extract it, our object is to excite the contraction of the womb, and make it in due time expel the secundines. This gives little pain, and may be attended with most important consequences to the future health or comfort of our patient. I need scarcely, I think, add, that in every case, more especially in those where the labour has been tedious, or the woman has been subject to hemorrhage,

we ought not to leave the bed-side, but should examine frequently, to ascertain that there is no unusual discharge;

The instant a woman is seized with hemorrhage after delivery, we ought to take steps for exciting the contraction of the uterus, upon which alone we place our hopes of safety\*. Two very powerful means are at all times within our reach. The application of cold, and the introduction of the hand into the cavity of the uterus.

The retention of the placenta is not in general the cause of the hemorrhage, but a joint effect, together with it, of the torpor of the uterus. Our primary object then is not to extract the placenta, but to excite the uterus to brisker action. How improper and dangerous then must it be to thrust the hand into the uterus, grasp the placenta, and bring it instantly away; or to endeavour to deliver the placenta by pulling forcibly at the umbilical cord. By the first practice, we are apt to injure the uterus, and certainly cannot rely upon it for checking the hemorrhage. By the second, we either tear the cord or invert the uterus.

When we introduce the hand, we conduct it to the placenta, using the cord only as a director. We do not attempt to bring it away, but press upon it with the back of the hand, to excite the uterus to separate it; or, if it be already detached, and lying loose in the cavity of the womb, we move the hand gently to stimulate the uterus, but neither with-

\* It is not my intention to advise immediate interference, although the discharge be a little more than usual; but whenever it is considerable, or is affecting the pulse, or producing other perceptible effects on the system, we ought not to delay. It is a fatal error to wait until dangerous symptoms appear; many weeks of suffering, perhaps death itself may be the consequence. I cannot therefore agree with the ingenious M. Le Roy, in the following directions respecting hemorrhage after the birth of the child. "Quand la femme n'est pas délivrée & qu'il survient une perte, il faut attendre patiemment s'il ne se manifeste aucun symptôme alarmant parce que cette perte cesse quelquefois d'elle-même. Mais quand les symptômes sont alarmans & qu'on craint pour la vie de la femme, lorsque la matrice s'engorge & se degorge alternativement, lorsqu'enfin la femme se plaint d'éblouissemens dans les yeux deviennent convulsifs; que le pouls devient trop petit; que les extrémités sont froides; le visage d'une pâleur mortelle; que le sang traverse le lit: qu'on entend dans le ventre des gonnillemens qui annoncent la résolution des forces vitales; alors il faut employer des moyens propres à redonner du ressort à la matrice." Lecours, p. 50.



draw it, nor extract the placenta, until we feel the womb contracting.

The contraction of the uterus will be powerfully assisted by the application of cold. The quantity of clothes should be lessened; but our principal object is to apply cold as to a topical remedy. Cloths dipped in cold water should be laid suddenly upon the belly, or cold water may be thrown upon it. In obstinate cases it has been found useful to project it forcibly with a syringe, or to throw it up into the uterus itself. If we have not a syringe at hand, we may in desperate cases dip a sponge or a piece of cloth in cold water, and carry it in the hollow of the hand up to the fundus uteri. Nay, ice itself has, with happy effects, been introduced into the womb. In general, however, the external application of cold will be sufficient to save the patient. I feel confident in advising it, and can say, without reserve, that I have never known any bad consequence result from it.

In those cases where the uterus is spasmodically contracted, we must slowly and cautiously dilate the stricture, so as to get the hand into the upper cyst of the uterus; and, in doing so, we shall be greatly assisted by applying cold water to the abdomen, or dashing water smartly on it from a cloth. Afterwards, the same attention is to be paid to the contraction of the uterus as in the former case.

When it happens that part of the placenta adheres pretty firmly to the uterus, we are not to be rude in our attempts to separate it, but should remember that there can be no danger in being deliberate. It is too much the practice with some midwives, to trust more to their fingers than to the contraction of the uterine fibres; the consequence of which is, that they tear the placenta, and irritate the womb. Yet it is certain, on the other hand, that gentle attempts to separate it are sometimes necessary; but these should be so cautiously and deliberately made, as not to lacerate the placenta. The fingers should be very slowly and gently insinuated betwixt the uterus and the placenta, so as to overcome the adhesion, which is seldom extensive. I have known the placenta retained for four days, by an adhesion not larger

than a shilling. This case proved fatal by loss of blood, which continued to take place, I understand, in variable quantity during the whole time. No attempts were made to relieve the woman, until she was dying.

We can in general easily save the patient in flooding, if we are on the spot when it happens; but if much blood have been lost before we arrive, the strength may be irreparably sunk. In those cases where great weakness has been produced, we must not only endeavour to excite the uterine contraction in order to prevent farther injury, but we must also husband well the power which remains. The hand is to be immediately introduced into the womb, and must be kept there, moving it gently, until the fibres contract; and until this take place, neither the hand nor the placenta should be withdrawn. Cold water is to be dashed on the abdomen, gentle pressure is to be made by the hand on the region of the uterus, and the whole belly firmly supported with a bandage, provided that can be applied without moving the patient much. But as every exertion is dangerous, motion must be avoided; and upon no account is the patient to be shifted or disturbed for some time. By imprudent attempts to raise the patient, or "to make her more comfortable," she has sometimes suddenly expired.

The state of the stomach is to be watched, preventing, as far as we can, that feeling of sinking which is apt to take place in all floodings. This is to be done by keeping up the action of that important organ with soup, properly seasoned, and given in small quantity, but pretty frequently repeated. Cordials, as, for instance, Madeira, diluted or pure, should be given in small doses regularly for some time to support the strength; but after recovery begins to take place, and the pulse steadily to be felt, they should be omitted or decreased; for if persisted in to the same extent, fever or inflammation may be excited. Opiates are of greater service in all cases of uterine hemorrhage after delivery. They are among the safest and best cordials we can employ, and must in every instance be exhibited. The dose ought to be proportioned to the urgency, varying from fifty to sixty drops.

In some instances, when the debility was great, a hundred drops of the tincture, or five grains of solid opium, have been given at once, and afterwards three grains every three hours till the patient was out of danger. Nor does this practice, against which I was at first prejudiced from theory, ever prevent the contraction of the uterus, or produce afterwards any bad effect. Opiates supply the place of wine, and are infinitely safer.

We must be careful neither to give nourishment nor cordials so frequently as to load the stomach, which produces sickness and anxiety, until vomiting remedy our error. This last symptom, when moderate, is not always unfavourable, for it sometimes excites more powerfully the contraction of the womb. The rising of the pulse, and relief of the patient after it, is to be ascribed not so much to any direct power which this operation has of invigorating the system, as to the consequent removal of sickness and oppression. If this effect do not follow from vomiting, the case is very bad. Solid opium is the most effectual remedy against repeated vomiting. It must be given in the dose of at least three, and in some cases, four grains.

¶ When the hemorrhage has produced complete syncope, the state of the patient is very alarming. Yet the danger is not the same in every case, for some women faint from slighter causes than others. La Motte relates one case where the patient fainted no less than twenty times in the course of the night. She is to be preserved in a state of the most perfect rest, the face is to be smartly sprinkled with cold water, a little wine or brandy, or spiritus ammoniæ aromaticus given after the opiate rouses the system. Afterwards, warmed spiced wine may be given in small quantity, and warm cloths applied to the feet. Friction on the region of the stomach, with some stimulating embrocation, as hartshorn and spirits, may be useful. I need not add, that the patient must, in these awful circumstances, be carefully watched; and that, if the expression be allowed, we must obstinately fight against death.

It was at one time the practice to prevent the patient from



sleeping, or indulging that propensity to drowsiness which often follows hemorrhage\*. But we can surely, at short intervals, give whatever may be necessary to the patient, without absolutely preventing sleep, or rather slumber, for the patient never sleeps profoundly. We are to attend so far to the advice, as not to allow the slumber to interfere with the administration of such cordials or nourishment as may be requisite.

When the placenta is rashly extracted immediately after the delivery of the child, or suddenly taken away upon the accession of hemorrhage, then we find that the uterus does not contract properly, and the vessels pour out blood plentifully. This in part escapes by the vagina, but much of it remains in the cavity of the uterus, where it coagulates, and hinders the free discharge of the fluid by the vagina. But blood may be still poured out into the cavity of the womb, which becomes distended, and that often to a great size. Thus it appears, that after delivery the hemorrhage may be sometimes apparent, sometimes concealed. When it flows from the vagina, it is always discovered by the patient; but when it is confined in the uterus, it is only known by its effects; the pulse sinks, the countenance becomes pale, the strength departs, and a fainting fit precedes the fatal catastrophe.

Even when the placenta has not been rapidly extracted, hemorrhage may come on, and most frequently it, in this case, proceeds from rash exertion, or much motion. In an uncivilized state of society, we find that almost immediately after delivery, the parent is able to walk about; but women brought up in the European modes of life, cannot use the same freedom. Motion not only disorders the action of the uterus, and impairs its contraction, but also powerfully excites the circulation.

The continued application of a great degree of heat, mental agitation, and the use of stimulants, may also contribute to the production or renewal of hemorrhage.

\* Even some modern writers have an opinion that sleep is directly injurious. "*Somnus ejusmodi hemorrhagias recrudescere facit.*" Stoll. *Prelectiones*, vol. ii. p. 199.

A partial or complete inversion of the uterus, is another cause of hemorrhage, and which can only be discovered by examination.

Sometimes a partial or irregular contraction of the uterine fibres takes place, and the person is tormented by grinding pains, accompanied by repeated hemorrhage \*.

The retention of a small portion of the placenta, which has firmly adhered to the uterus, is also a cause of hemorrhage, and the discharge may be renewed for many days, until the portion be expelled.

It may also happen that, from some agitation of mind, or morbid state of body, the uterus may not go regularly on in its process of contraction or restoration †, to the unimpregnated state. In this case, the cavity may be filled with blood, which forms a coagulum, and is expelled with fluid discharge. The womb may remain stationary for a considerable time, and the coagula be successively expelled, with slight pains, and no small degree of hemorrhage. These symptoms very much resemble those produced by the retention of part of the placenta, and cannot easily be, with certainty, distinguished from them. We have, however, less of the foetid smell, and we never observe any shreds or portion of the placenta to be expelled, whilst the coagulum, if entire, has exactly the shape of the uterine cavity.

Lastly, we find, that if exertion have been used before the uterus has been perfectly restored, there may be excited a draining of blood, which does not come, in general, very rapidly; but, from its constant continuance, amounts ultimately to a considerable quantity, and impairs the health and vigour of the woman. This has been called *menorrhagia lochialis*.

\* When the abdomen has been bandaged too tightly, the parts within are injured. The patient is restless and uneasy; the pulse is frequent; she complains of pain about the uterus; and numbness in the thighs. Sometimes the lochia are obstructed; sometimes, on the contrary, pretty copious hemorrhage is produced. Relief is obtained by slackening the bandage; by giving an anodyne; and, if there be no hemorrhage, by fomenting the belly.

† This, at first, is owing to muscular contraction; afterwards, absorption forms part of the process. But if these operations shall be interrupted, or injured, then the vessels, which are still large, not being duly supported, will be very apt to pour out blood.

When hemorrhage, whether external or internal, takes place, in moderate quantity, immediately after the expulsion of the placenta, and when the system does not seem to suffer materially, we may be satisfied with firmly supporting the uterus by external pressure, and applying a dry cloth closely to the orifice of the vagina. The blood thus coagulates in the uterus, which being supported by the external pressure or bandage, does not distend, and the action of its fibres is soon excited. After-pains are to be expected, but the fear of hemorrhage is removed. In some instances, when we have had no external hemorrhage, and the blood has been slowly poured into the uterine cavity, little inconveniences is produced for some time. But presently, by the pressure of the womb on the neck of the bladder, a retention of urine is caused, attended with much pain in the belly. This is in general instantly removed by introducing the finger into the vagina, and raising up the uterus. If it should not, the catheter must be employed.

But whenever hemorrhage takes place to such an extent as to endanger the patient, and produce the effects I have already mentioned, then we must interfere more actively; and I need not attempt to prove, that the only security consists in uterine contraction. This is to be excited by the application of cold, and by the introduction of the hand, not simply to extract the coagula, but to stimulate the uterus, and rather make it expel them. Should this be tedious, it may be assisted by the injection of cold water into the womb. We must also proceed with opiates, cordials and nourishment upon the rules formerly stated for recovery; and we shall do well not to be in a hurry to quit our patient, for the hemorrhage may be renewed, and the woman be lost before we can see her.

When the hemorrhage proceeds from irregular action of the uterus, and is attended with grinding pain, a full dose of tincture of opium is of advantage, and seldom fails in relieving the patient.

If the placenta have been torn, and a portion of it remain attached to the uterus, the hemorrhage is often very obsti-



nate. Both clotted and fluid blood will be discharged repeatedly. An offensive smell proceeds from the uterus, and at last the portion of placenta is expelled in a putrid state, after the lapse of many days. By examination, the os uteri will be found soft, open, and irregular.

If by the introduction of the finger we can feel any thing within the uterus, it should be cautiously extracted; but we are not to use force or much irritation either in our examinations or attempts to extract, lest we inflame the womb. It is more advisable to plug the vagina, and even the os uteri, so as to confine the blood, and excite the uterine contraction. We may also inject some cold and astringent fluid for the same purpose, or throw a full stream of cold water into the uterus, from a large syringe, by way of washing out the portion of placenta, if it have become nearly detached. A gentle emetic sometimes promotes the expulsion. The bowels are to be kept open, and the strength supported by mild and nourishing diet; but we must take care on the other hand not to fill the vessels too fast. If febrile symptoms arise, the case is still more dangerous, as I will presently notice.

When the hemorrhage proceeds from an interruption of the process of restoration, our principal resource consists in exciting the contraction of the womb by the use of clysters—by friction on the abdomen—by injecting cold and astringent fluids into the womb—by the exhibition of a gentle emetic—and by throwing cold water from a syringe upon the abdomen when the womb is expelling the coagulum. We also check the hemorrhage, and save blood, by the prompt application of the plug, and diminish the action of the vessels themselves, by allaying or removing every irritation; by avoiding the frequent use of stimulants, or attempts to fill the vessels too quickly. The feeling of sinking, sickness, tendency to syncope, &c. are to be obviated by the means already pointed out.

Lastly. The menorrhagia lochialis is to be cured by rest, cool air, the use of sulphuric acid or other tonics, bathing the pubis or back with cold water, and injecting an astringent fluid three or four times a-day into the uterus. If the pulse

be frequent, the exhibition of the digitalis for a short time will be of advantage. Pain in the back generally attends this disease, and is sometimes so severe as even to affect the breathing. In this case, a warm plaster applied to the back is often of service: and, if the pulse be soft, an anodyne should be administered. In slight cases, the application of cloths dipped in cold vinegar, to the back, does good.

### CHAP. III.

#### *Of Inversion of the Uterus.*

INVERSION of the uterus implies, that the inside is turned out, and down into the vagina. It may take place in different degrees. When complete, it protrudes out of the vagina, and exactly resembles the uterus after delivery, only the mouth is turned upward. The vagina, is, in this case, also partly inverted, so that the tumour is of considerable length. When it is partial, the tumour is retained altogether, or chiefly within the vagina, and the fundus only protrudes to a certain degree through the os uteri, forming a firm substance, something like a child's head<sup>1</sup>. When the uterus is inverted, the woman feels great pain, generally accompanied with a bearing-down effort, by which a partial inversion is sometimes rendered complete. The pain is obstinate and severe, the woman feels very weak, the countenance is pale, the pulse feeble, and often imperceptible, a hemorrhage very generally attends the accident, and often is most profuse. But it is worthy of notice, that complete inversion sometimes is not accompanied with hemorrhage\*, whilst a very partial inversion may be attended with a fatal discharge. Fainting, and convulsions, are not unfrequent attendants, although the hemorrhage have been trifling.

Inversion, in a great majority of instances, depends upon the midwife† endeavouring to extract the placenta, by pull-

\* This was the case, in the instance related by Dr Hamilton, Med. Com. Vol. XVI. p. 315.—In the case by Mr Brown, the hemorrhage was considerable. Annals of Med. Vol. II. p. 277.

† Chapman relates a case of inversion, where the midwife pulled forcibly at the uterus, and excited convulsions, fainting, and death. Case 29. p. 123.

ing the cord. Sometimes the uterus is directly pulled down, and the placenta still adheres; in other cases, it is separated. It may also happen, if the child be allowed to be rapidly expelled; for if the cord be short, or entangled about the child, the fundus may receive a sudden jerk, and become inverted.

Inversion may terminate in different ways. It may prove rapidly fatal by hemorrhage; or it may excite fatal syncope, or convulsions; or it may operate more slowly, by inducing inflammation, or distension of the bladder; or after severe pains and expulsive efforts, the patient may get the better of the immediate injury, the uterus may diminish to its natural size, by slow degrees, and give little inconvenience<sup>2</sup>; or it may discharge foetid matter, and give rise to frequent debilitating hemorrhage; or hectic comes on, and the patient sinks in a miserable manner.

If inversion be discovered early, the uterus may be replaced. If it have protruded out of the vagina, it is, first of all, to be returned within it; if it have not, we proceed directly to endeavour to return it within the os uteri, by cautiously grasping the tumour in the hand and pushing it upwards, within the os uteri. This may be facilitated by pressing up the most prominent part of the fundus in the direction of the axis of the uterus, so as gradually to undo the inversion, or re-invert the protruded womb: a piece of wood with a round head has by some been used in this way; but the fingers are safer. If we push directly without compressing the tumour, we sometimes bring on violent bearing-down pains. These are occasionally attended with increase, or renewal, of flooding. If we succeed, we should carry the hand within the uterus, and keep it there for some time, to excite its contraction. If the placenta still adhere, we should not remove it until we have reduced the uterus; after which, we excite the contraction of the womb to make it throw it off\*. It is sometimes long before the pulse becomes steadily to be felt†. Occasionally, after the reduction, when the patient

\* In a case related in *Memoirs of Med. Soc.* Vol. V. 202, the placenta was allowed to remain five days after reduction, but this is a hazardous practice.—Perfect, case 71, brought it away after four hours.

† Case by Dr Duffield, in *Trans. of Coll. at Phil.* 167.



is seeming to do well, she is seized with a fit and dies\*. Or, she may remain long weak, and have swelled feet †.

If inversion have not been discovered early, it is more difficult, nay, sometimes impossible to reduce it, owing chiefly to contraction of the os uteri. Dr Denman says, that he has found it impossible to reduce it, even four hours after it took place; and in a chronic inversion, he never once succeeded. In such cases, it is not prudent to make very violent efforts to reduce the uterus, as these may excite convulsions, &c. We must in every instance alleviate urgent symptoms, such as syncope, retention of urine, or inflammation, by suitable means. I may further observe, that when a patient, after delivery, complains of obstinate pain, or bearing-down, or suppression of urine, or is very weak, we should always examine per vaginam. If the uterus be inverted we may feel the tumor, and we may find the hard womb to be absent in the belly, or lower down than it should be. If this examination be neglected, the patient may be lost. I have known the first intimation given to the practitioner, to be his finding no uterus in the belly, when it was opened after death. Examination is of the utmost consequence.

When the uterus cannot be replaced, we should at least return it into the vagina. We must palliate symptoms, apply gentle astringent lotions, keep the patient easy and quiet, attend to the state of the bladder, support the strength, allay irritation by anodynes, and the troublesome bearing down by a proper pessary; the bad effects of neglecting or removing this are to be seen in La Motte's 385th case. If inflammation come on, we must prescribe blood-letting, laxatives, &c. In this way, the uterus contracts to its natural size, and the woman menstruates as usual, but generally the health is delicate. Sometimes the uterus becomes scirrhus, or gangrenous sloughs take place ‡.

\* Case by Dr Albert. *Annals of Med.* Vol. V. 390.

† Mr White's case, *Med. Comment.* Vol. XX. 247.

‡ Schmucker's *Surgical Essays*, art. xvii.—A case is given in *Med. Jour.* VI. 367, where appearance of gangrene, from strangulation, took place. The womb was scarified, and the swelling quickly disappeared. The patient recovered.

If the uterus discharge foetid matter, and hemorrhage take place, the strength is apt to sink, and the patient dies hectic. Astringent applications, with attention to cleanliness, good diet, and the occasional use of opiates may give relief; but if they do not, we are warranted to prefer extirpation of the uterus, to certain death. This operation has been repeatedly successful<sup>3</sup>, and is performed by applying a ligature high up, and cutting off the tumor below. But it must also be remembered, that in some cases where the inverted uterus has been either intentionally extirpated, or mistaken for a polypus\*, death has followed.

Inversion, when long continued, may be confounded with prolapsus, or polypus: from the first, it is distinguished by the shape and by the absence of the os uteri; from the second, by examination, and finding the os uteri embracing the polypus†. The history will likewise assist in the diagnosis.

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#### CHAP. IV.

##### *Of After-pains.*

Few women proceed through the early part of the puerperal state, without feeling attacks of pain in the belly, which are called after-pains. These are generally least severe after a first labour. They proceed from the contraction of the uterus in an irregular manner, excited by the presence of coagula, or other causes, and each severe pain is generally followed by the expulsion of a clot. They come on usually very soon after delivery, and last for a day or two. They are often increased, when the woman first applies the child to the breast. They are distinguished from inflammation of the uterus or peritoneum, by remitting or

\* In a case related in *Recueil des Actes de la Société de Santé, de Lyon*, the uterus was taken for a polypus, and the ligature applied. The mistake being discovered, it was instantly withdrawn, but the woman died in a few days.

† In one case, the os uteri adhered to the neck of the polypus, and gave rise to appearance of inverted uterus. *Mem. of Med. Soc. Vol. V. p. 11.*

going off. The belly is not painful to the touch, the uterine discharge is not obstructed, the patient has no shivering nor vomiting, the milk is secreted, and the pulse is seldom frequent. When the pulse is frequent, then we must always be on our guard; for if this be the case before the accession of the milk fever, the patient is not out of danger, and if any other bad symptom appear, we must be prompt in our practice. After-pains may also be caused by flatulence and costiveness, which we know by the usual symptoms; but a combination of this state with uterine after-pains, is often attended with a frequency of the pulse, and may give rise to a fear that inflammation is about to come on but other symptoms are absent. Uterine after-pains are relieved by opiates and fomentations. When the bowels are also affected, a laxative is useful, and this is always proper when the pulse is frequent. A severe constant pain in the hypogastric region is sometimes produced by an affection of the heart, and proves fatal, yet the uterus is found healthy.

Upon this subject, it may not be improper to mention, that a young practitioner may mistake spasmodic affections or choleric pains for puerperal inflammation; for in such cases there is often retching and sensibility of the muscles, which renders pressure painful. But there is less heat of the skin, the tongue is moist, the pulse, though it may be frequent, is soft, the feet are often cold, the pain has great remissions if it do not go off completely, there is little fulness of the belly, and the patient is troubled with flatulence. It requires laxatives, antispasmodics, anodyne clysters, and friction with camphorated spirits. Blood drawn in this disease, after it has continued for some hours, even when the woman is not in childbed, is sizy; and it is always so in the puerperal as well as the pregnant state, although the woman be well.

It is necessary to attend carefully to the duration and situation of pain after delivery, and to the symptoms connected with it. For it may proceed from inflammation of the viscera; or in some cases it is felt near the groin, and may be the forerunner of swelled leg; or about the hip, ending in a kind



of rheumatic lameness; or in consequence of the application of cold, pain may be felt in some part of the recti or oblique muscles, which, if not removed by fomentations and frictions, may end in abscess, which frequently is long of bursting, and excites hectic fever. It ought to be opened with a lancet or caustic.

Rheumatism affecting the muscles of the abdomen and pelvis, is accompanied with less fever than puerperal inflammation, and wants the other symptoms. The pain is shifting and aching, or gnawing, though sometimes it is pretty sharp, like a stitch. It is relieved by friction, with laudanum, by sinapisms, and by mild diaphoretics, bark, and the usual treatment. When speaking of rheumatic pain, it may not be improper to mention, that chronic rheumatism, especially of the extremities, is very troublesome when it occurs after parturition. It requires the usual remedies. Cod-liver oil, in dozes of half an ounce, three times a-day, has been much recommended. I have formerly noticed those pains in the limbs which may succeed the use of the crotchet.

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## CHAP. V.

### *Of Hysteralgia.*

By hysteralgia, I understand uterine pain not proceeding from inflammation. It comes on within three or four days after delivery, and attacks in general very suddenly. Perhaps the patient has risen to have the bed made; becomes sick, or vomits, and is seized with violent pain in the lower part of the belly, or between the navel and pubis. There is no shivering, at least it is not a common attendant, and the pulse become very rapid, being sometimes above a hundred and twenty, the skin is hot, the lochia usually obstructed, and the uterine region is somewhat painful on pressure. After some hours, the severity abates, and presently by proper means the health is restored.

As the lochial discharge is usually obstructed, this obstruction has been considered as the cause of the pain and other symptoms; but it is merely an effect, and sometimes does not

exist. The cause appears to consist in a deranged state of action in the uterus, which is productive of spasm of the uterine fibres, and sometimes of the intestines. This is more apt to occur after a severe or tedious, than after an easy labour, but it may occur in any case, especially if exposed to cold. The symptoms will vary a little in severity and in appearance, according as the uterus alone is affected, or as spasm of the bowels is combined with the uterine pain. It is distinguished from inflammation by the sudden nature of the attack, the absence of shivering in general, the pain becoming speedily more severe than it does at the same period of inflammation; and frequently it greatly remits, or goes almost entirely away for a short time. It is possible, however, for this state, especially if it be neglected, to excite inflammation, which is marked by an attack of shivering, constant pain, more or less severe, according to the part affected, and an obstinate continuance of the fever.

The first thing to be done, is to administer a clyster to open the bowels. Then the belly is to be fomented, and if speedy relief be not obtained by these means, an anodyne injection is to be given, and the saline julap is to be taken freely, with the addition of a little antimonial wine, in order to excite a free perspiration. If the symptoms continue, laxatives are useful, and a blister must be applied to the pained part of the belly to prevent inflammation.

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## CHAP. VI.

### *Of Retention of Part of the Placenta.*

IF either the whole, or a considerable portion of the placenta, be left in utero for some time, the patient is exposed to great danger. Hemorrhage is not the only risk, for in many cases, severe head-ach, hysterical affections, sickness, nausea, prostration of strength, and fever have taken place, and continued until the placenta have been expelled, after which the patient has begun to recover. On the other hand,

it has, though more rarely, occurred, that the placenta, having been retained for a length of time, has been expelled, before these symptoms have become urgent; but they have afterward gradually increased, and carried off the patient \*. Sometimes the symptoms run so high, or the portions of the placenta are so obstinately retained, that the patient sinks under the disease, as in ordinary cases of hectic, with frequent small pulse, burning heat of the hands and feet, profuse perspirations, and universal emaciation; or dies with symptoms similar to those of putrid fever; or is carried off suddenly by a convulsion, or an attack of hemorrhage.

These symptoms have a very indefinite duration, for sometimes the patient dies in a very few days; in other instances they are protracted for two or three weeks †. Sometimes no hemorrhage takes place during the whole course of the disease; but occasionally, repeated hemorrhages do occur, adding greatly to the debility of the patient. In several cases, inflammation has come on, and spread to the intestines. In some of these, the placenta has been afterwards expelled, in others extracted; but very few have recovered. On inspecting the uterus, it has either been found black, as if it had been gangrenous, or in a state of high inflammation, or of suppuration, whilst the parts in the vicinity were in various stages and degrees of inflammation.

Now, when these symptoms have taken place, our object ought to be to remove the cause, and support the patient under the disease. I am aware, that some have attributed these symptoms not to the placenta, but to concomitant circumstances, such as injury done with the hand in endeavouring to take it away. But we find that they take place when the whole of the placenta has been left, without any attempt

\* In a case related by Mr Whyte, the secundines, after a clyster, came away in a putrid state on the fifth day. On the sixth, the patient was much oppressed, had fœtid breath, &c. on the twelfth, an eruption appeared, and she died on the twenty-second.

† Dr Perfect relates a case, in which the secundines were retained till the eighth day, when the patient died. Her stomach rejected all food and medicine, she had weak quick pulse, hiccup, and *subsultus tendinum*. Vol. II. p. 390.—In another case, the placenta was retained till the thirteenth day, and the woman died on the twentieth, p. 381.



having been made to remove it. They are produced when any substance is left to corrupt in utero\*. They continue as long as it remains, and they usually cease when it is expelled.

It may be proper to examine, with the finger introduced into the os uteri, whether any portion of the placenta can be felt and removed; but generally this cannot be freely done, for the uterus itself, as well as its mouth, is hard and contracted, and no violent or painful attempt with the hand or finger ought to be made. But when we can easily feel and act upon a portion, we ought slowly and gently to endeavour to bring it out; and if the whole of the placenta have been left, such attempts are still more necessary, and likely to succeed. The os uteri often affords considerable resistance to the introduction of the hand, in cases where the retention has subsisted for some days; but by very slow and gentle efforts, such as are scarcely felt by the patient, it may be dilated, and sometimes it yields very easily, or is not at all contracted. If, however, it be rigid and unyielding, we must not use violence; but this condition is rarely conjoined with retention of the entire placenta.

When a portion of the placenta is retained, we may derive advantage, from injecting frequently, warm water, or warm infusion of chamomile flowers, or water with a very little muriatic acid added to it. These injections may be made, by fixing a female catheter to an elastic-gum bottle; or a syringe with a long pipe may be employed.

Sometimes natural or artificial vomiting assists the expulsion.

The patient should be allowed the free use of fruit and vegetable acids, and light mild diet should be given in small quantity at a time. The bowels ought to be kept open, and opiates should occasionally be given to allay irritation. Vomiting and nausea may be checked or mitigated when urgent, by effervescing draughts. Bark, in small doses, has been given, but I cannot place much confidence in it. When

\* Similar symptoms have been produced by the head of the child being left in utero. *Perfect*, Vol. II. p. 89.

there is a fulness about the abdomen, and tendency to inflammation, purgatives are of service. When the nervous system is much disturbed, the camphorated mixture may be given in its usual dose.

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## CHAP. VII.

### *Of Strangury.*

AFTER severe labour, the neck of the bladder and urethra are sometimes extremely sensible; and the whole of the vulva is tender, and of a deep red colour. This is productive of very distressing strangury, which is occasionally accompanied with a considerable degree of fever. It is long of being removed, but yields at last to a course of gentle laxatives, opiates, and fomentations. Anodyne clysters are of service.

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## CHAP. VIII.

### *Of Pneumonia.*

It is unnecessary to detail the symptoms of inflammation of the lungs or pleura. It is sufficient to say, that this disease is not uncommon in the puerperal state; and if there be such a state of the lungs during pregnancy, as tends toward phthisis, that disease is exceedingly apt to be rapidly induced after delivery.

Pleurisy requires on the first attack copious blood-letting, laxatives, and blisters, which are never to be omitted. If the early stage has passed over, the use of the lancet is doubtful, and it is better to trust to digitalis given freely, and the application of blisters. Laxatives are also not to be neglected.

## CHAP. IX.

*Of Spasmodic and Nervous Diseases.*

PALPITATION is not an uncommon disease after delivery. It usually attacks the patient suddenly, and often after a slight alarm. She feels a violent beating in the breast, and sometimes has a sense of suffocation; she has also a knocking within the head, with giddiness, and a feeling of heat in the face. The pulse is extremely rapid during the fit, and the patient is impressed with a belief that she is going to die. After the paroxysm, the mind is left timid, and the body languid. Sometimes it is succeeded by a profuse perspiration; and should the fits be frequently repeated, the temperature is variable during the intervals, and the stomach is filled with gas. This is often a very obstinate, but it is not a dangerous disease, unless it proceed from uterine disease, marked by pain and swelling of the belly. It is to be relieved by giving, during the paroxysm, a liberal dose of ether and laudanum; and during the intervals, antispasmodics, laxatives, and tonics are to be employed. As soon as possible, the patient should remove to the country.

Colic, cramp of the stomach, hysteric fits, hiccups, syncope, and dyspnœa, are to be treated upon general principles. They are most readily removed by full doses of opium, and other antispasmodics, and clearing out the bowels with purgatives.

There is a species of dyspnœa, that depends upon exertion of the muscles of respiration during labour, or distention of the abdominal muscles. When the abdominal muscles are affected, the person often feels the difficulty of breathing, chiefly during expiration. It is relieved, by tightening a little the compress round the belly, and giving thirty drops of laudanum. When the diaphragm is affected, the uneasiness is usually greatest during inspiration; and there is often a pain in the side, or in the back, or about the pit of the stomach, which may be very severe. It is attended,



sometimes, with a sense of stuffing in the breast; in other cases, with an acute feeling of suffocation, or very sharp pains across the lower part of the thorax, with deadly paleness, and the pulse is extremely rapid. A very large dose of laudanum, with ether or volatile tincture of valerian removes the spasm; if not, a sinapism must be applied. These affections come on within a few hours after delivery. The spasm of the diaphragm is to be distinguished from pleurisy, by its coming on suddenly, and being very acute; whereas, inflammation comes on more slowly, and is often preceded by a shivering fit, there is more cough, and the pulse at first is not so frequent, but is sharp.

Dyspnoea is also occasionally produced by the roller being too tight.

Colic may occur within a few days after delivery. It attacks suddenly, and generally in the evening. It is not preceded by shivering, but is sometimes accompanied with sickness. The pulse may at first be either slow or of the natural frequency, but soon becomes frequent. The pain is subject to exacerbation and remission, but sometimes does not entirely go off for several hours. The chief risk of this disease is the induction of inflammation, if the irritation be not soon removed. The best remedy is a large dose of laudanum given in a clyster, and fomentations are to be used at the same time. It is generally beneficial to precede the anodyne by a saline clyster. If the symptoms do not go entirely off, the saline julap with laudanum is of service. If there be much flatulence tincture of asafoetida and hyocyamus are proper. Cramp in the stomach is very dangerous, when it occurs within three weeks after delivery. It requires the immediate exhibition of at least sixty, perhaps a hundred drops of laudanum, with a drachm of sulphuric ether, or two drachms of spiritus ammoniac aromaticus; a sinapism is also to be applied to the region of the stomach.

Pain in the region of the kidney sometimes proves very troublesome for two or three days after delivery. It comes in paroxysms, which are relieved by sinapisms, fomentations, clysters, purges, and opiates.

## CHAP. X.

*Of Ephemeral fever or weed.*

THE increased irritability of the system, as well as the delicacy of particular organs after delivery, render women at that time peculiarly liable to febrile affection. Some of these seem to arise from the general irritability of the whole nervous system, others from local affection of the heart, the bowels, or the uterus. The first of these symptomatic fevers, is generally pretty easily recognised by the sensibility of the breasts; the others, particularly that connected with the state of the womb, are often more ambiguous, the local symptoms being in many cases insidious.

The ephamera, or weed, as it has been called, is a fever usually of short duration; the paroxysm being completed generally within twenty-four, and always within forty-eight hours; for if it continue longer, it becomes a fever of a different description. It proceeds from great susceptibility of the nervous system, by which slight exposure to cold, mental agitation, or similar causes, excite a universal disorder of the frame. It consists of a cold, a hot, and a sweating stage; but if care be not taken, the paroxysm is apt to return; and we have either a distinct intermitting fever established, or sometimes, from the co-operation of additional causes, a continued, and very troublesome fever is produced.

This disease, which in its simplest form is very much of a nervous nature, generally makes its attack within a week after delivery. It may be excited by exposure to cold, irregularities of diet, fatigue, exhaustion, passions of the mind, or want of rest. It is sometimes directly ushered in with a fit of palpitation, or is excited by a frightful dream, from which the patient awakes in a shivering fit, with a rapid pulse; or the chill comes on, accompanied with pain in the back and head, after some slight alarm, or injudicious exposure to cold. When the cold stage has continued for some time, the hot one commences, and this ends in a profuse perspiration,

which either carries off the fever completely, or procures a great remission of the symptoms. The head is usually pained, especially over the eyes, in the two first stages. The pulse is extremely rapid, until the third stage has continued for some time; it is also subject to very great irregularities, and is very changeable in its degree of frequency. The thirst is considerable, the stomach generally filled with flatus, and the belly bound. The mind often is weakened, and the patient is much afraid of dying. In some instances, she is slightly delirious; in others, she has shifting pains in the abdomen. If the paroxysm be repeated, the secretion of milk is diminished.

The paroxysm continues for some hours, and then may completely go off, not to return again. But in other cases, it recurs frequently, being always preceded by a cold fit, and often with a pain in the back; and sometimes the fit begins regularly one or two hours sooner every succeeding day. It is more favourable when the fit postpones. When this disease is not combined with any local injury, it is less dangerous than most fevers occurring in child-bed; but if it recur very frequently, and be attended with much debility, the danger increases in proportion to the continuance of the disease. Local derangement is apt to take place very suddenly in the course of this ailment; the breasts are peculiarly liable to become inflamed. A fatal termination is usually preceded by a coma, or vomiting of dark coloured matter.

Delicate women, and those who have suffered much in parturition, are chiefly affected with this disease, but all are more or less liable to it.

It is distinguished from symptomatic fever arising from local inflammation, by the absence of the particular pain, and other specific symptoms, which attend these fevers, whilst in them the pulse is usually at first not so rapid as in the ephemeral fever.

In the cold stage, we give small quantities of warm fluid, and apply a bladder filled with warm water to the stomach, or a warm flannel to the back, on the commencement of the chillness; or, if the patient be sick, and have a foul tongue,



a gentle emetic of ipecacuanha will be useful. Having hastened on the hot stage, we lessen very cautiously the number of the bed-clothes, and give saline julap with diluents, to bring on the sweating stage. When this is done, we are careful not to encourage perspiration too much, which increases the weakness, or brings out a miliary eruption, and renders the disease more obstinate. On the other hand, if the perspiration be too soon checked, the fever continues, or recurs more severely; a gentle sweat may be kept up for five or six hours by tepid fluids. Then we refrain from them; and when the process is over, the patient is to be cautiously shifted, the clothes being previously warmed. After the fit, if the patient is exhausted, a little wine may be given. In the whole paroxysm, we must watch against the sudden application of cold, which, in the two last stages, renews the shivering. When the fits recur, we may sometimes check them, by giving an opiate an hour before the expected time of accession, and applying warmth to the back and stomach the moment the chillness is felt. It is of great consequence to keep the bowels open, by aloes combined with hyocyamus, calomel, &c. Tonic medicines, such as bark, sulphuric acid, and chalybeates, are useful; and in some cases valerian may be joined to these with advantage. Sleep is to be procured by opiates. During the whole time, the strength must be supported by suitable diet; and as soon as possible, the patient should be carried to the country. If the fits return often, it is generally necessary to give up nursing.

If derangement of any organ should take place by the recurrence of this disease, or during the course of a first attack, it must be treated on general principles; and it is to be recollected, that the nature of the complaint is now changed, and the organ which is disordered claims our chief attention. Very frequently the breasts suffer, or the womb itself may be attacked. But we must be careful to distinguish such a modification of weed from a symptomatic fever, beginning like weed, but altogether arising from the state of the womb, or other organs. The distinction is important, that no time be

lost in combating the disease; which in the one case does not at first exist, in the other, is present ab origine. When the local affection is acute, the diagnosis is easy; but I wish it to be impressed on the mind of my reader, that it may also be mild, and require attentive inquiry to ascertain it satisfactorily.

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## CHAP. XI.

### *Of the Milk Fever.*

THE secretion of the milk is usually ushered in with a slight degree of fever, or, at least, a frequency of the pulse. But sometimes it is attended with a smart febrile fit, preceded with shivering, and going off with a perspiration. This attack, if properly managed, seldom continues for twenty-four hours; and during this time, the breasts are full, hard, and painful, which distinguishes this from more dangerous fevers. Sometimes, during the hot fit, there is a slight delirium. A smart purge generally cures this disease, and is often used, in plethoric habits, on the third day after delivery, to prevent it. Mild diaphoretics, during the hot stage, are also proper. Applying the child early to the breast is a mean of prevention.

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## CHAP. XII.

### *Of Miliary Fever.*

THE miliary fever begins with chilliness, sickness, languor, sometimes amounting to syncope, and frequency of pulse, with heat of the skin. There is also a sense of pricking or itching on the surface; and sometimes the extremities are numbed. The febrile symptoms usually continue for some time, before the eruption appears, often for four or six days. Previous to the eruption, the patient feels very much oppressed, and has a great weight about the chest; the spirits are low, and a sour smelted perspiration takes place in a profuse degree. The eyes are occasionally dull

and watery, or inflamed, and the patient has ringing in the ears. The tongue is foul, and its edge red as in scarlatina. Aphthæ sometimes appear in the throat. The lochial discharge is diminished or suppressed. Before the eruption is seen, the skin feels rough like the cutis anserina. Presently a number of small red pustules appear like millet seeds, which are felt with the finger to be prominent. In a few hours, small vesicles form on their tops, containing a fluid, first straw coloured, and then white or yellow. In two or three days small scales form, which fall off like scales. The pustules are generally distinct, but sometimes they form clusters. They appear first about the forehead, neck, and breast, and then spread to the trunk and extremities, but very rarely affect the face. Different crops of pustules may come out in the same fever. Burserius, and others, divide the pustules into several varieties; but most writers are satisfied with two, taken from the general appearance, the red and the white, and the first is attended with a milder disease than the second.

This disease is peculiarly apt to attack those who are weakened by fatigue, evacuations, or other causes; and hence we can easily explain, why women in child-bed should be subject to it.

Some have considered the eruption as altogether dependent on the perspiration. Others consider it, as in many cases, idiopathic; and both, perhaps, at times are right. We can only consider the disease as idiopathic, when the eruption mitigates the symptoms, when the fever goes off as the pustules arrive at maturity, and there is no other puerperal disease present, acting as an exciting cause. It does not appear to be contagious, unless connected with a fever which is so of itself, such as typhus.

Miliary eruption also occurs during child-bed, as a symptom, connected with puerperal diseases. It often accompanies the milk-fever, or the weed, when the perspiration is injudiciously encouraged; and this is by far the most frequent form, under which the febris miliaris appears. It never alleviates the symptoms. It may also accompany fe-



vers connected with a morbid state of the peritoneum or brain, which generally prove fatal; death being preceded by vomiting of dark coloured fluid. Women, much reduced, have also partial miliary eruptions, generally of the white kind, without fever, which requires no particular treatment.

Whether the miliary fever be idiopathic, or symptomatic, the treatment is the same. We endeavour, at first, to check or remove the fever, by means which I have pointed out in a former chapter.

When profuse perspiration, with or without eruption, takes place, we must cautiously abate it, by prudently lessening the quantity of bed-clothes, or making the bed-room cooler. The rest of the treatment consists chiefly in removing irritation from the intestines by the use of laxatives, and supporting the strength by light nourishing diet, whilst we use tonics, such as sulphuric acid or bark. These tend also to abate the perspiration, which is scarcely ever to be encouraged. The linen should be frequently changed. When the eruption suddenly recedes, we have been advised to renew the perspiration, apply blisters, and give musk and cordials, especially when convulsions are threatened. This dangerous retrocession, however, I have not met with, and apprehend that it very rarely occurs.

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## CHAP. XIII.

### *Of Intestinal Fever.*

WE shall presently have an opportunity of observing, that the state of the bowels frequently produces in children a very troublesome species of fever, which, though proceeding from a cause which has been some time in existence, makes its appearance suddenly. The same holds true with regard to women in child-bed, who, either from previous torpor or costiveness of the bowels during the end of gestation, or some error in diet after delivery, are seized, within eight or nine days, generally earlier, with fever, which passes for weed.

After an attack of shivering and chilliness; the patient becomes sick, oppressed at the stomach, and loathes food. The pulse is frequent, and the skin, except at the feet, feels, from the very first, hot to the touch of another person, though the woman herself complains of being cold. Afterwards she feels very hot, especially in the hands and feet;—she has no appetite,—is thirsty,—has a white slimy tongue,—is sick,—and occasionally vomits phlegm or bile, and is troubled with flatulence. The pulse is quick; she does not sleep, but rather slumbers, and is tormented with dreams and visions, and talks during her slumbers. Generally she complains of throbbing, often of confusion, but seldom of continued pain in the head. She has no fixed pain, nor any tumor in the belly, but complains rather of stitches or griping. The bowels may either be costive or loose; but in either case, the stools are foetid and dark coloured; and in general, laxatives operate both early and powerfully. The lochial discharge is not necessarily obstructed, nor does the secretion of milk, in many instances, suffer for many days. The eye and the countenance are nearly natural. The belly sometimes, in the course of the disease, becomes full and soft, as if the bowels were inflated, and this size occasionally continues during life. These symptoms may be complicated with others, proceeding from nervous irritation, such as palpitation, starting, &c. or in the course of the disease, new ones arising from injury of the function of the womb, may supervene, and are marked first by pains, and afterwards by tumefaction of the lower part of the belly, and pain in making water, or on passing the *sæces*. The duration of this fever varies from a few days to a fortnight.

On the first appearance of this fever, a gentle emetic of ipecacuanha should be administered; and afterwards, when the operation is over, we determine to the surface, by giving the saline julap with tepid drink. Then, in a few hours, we administer a dose of rhubarb and magnesia to remove offensive matter from the bowels; or, if necessary, we give a suitable dose of castor oil, or calomel. After this, if there be considerable griping, or a tendency to much purging, we

give an opiate-clyster, and repeat this every night till the bowels are less irritable, taking care, if they become costive, or the stools foetid, to interpose, occasionally, gentle laxatives. The great principle indeed on which we proceed, is the early and prompt evacuation of the offensive matter, whether bilious or feculent, from the bowels, and the prevention of re-accumulation. The diet must be very light, such as beef-tea, calves feet jelly, arrow root, &c. and if there be no diarrhœa, ripe fruit may be given. Ginger wine and water forms an excellent drink, and in a few days, such a quantity of Madeira wine may be given, as is found to impart a comfortable feeling, without inducing heat or restlessness. When the tongue becomes clean, small doses of colombo, or other bitters will be useful. If there be much nervous irritation or palpitation, or tendency to delirium, the camphorated julap is proper.

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#### CHAP. XIV.

##### *Of Inflammation of the Uterus.*

Inflammation of the womb may appear under two forms, the slight and the extensive. This is a distinction which those who are not much conversant in practice, may not be disposed to admit; but it will, nevertheless, be useful to describe them separately. The first begins within the 9th day, very like the ephemeral fever, and is considered by the nurse as a weed. The patient shivers, feels cold, is sick, and perhaps vomits. The pulse is frequent, but not hard nor sharp, the skin becomes warm, and between the cold and the establishment of the hot stage, the patient complains of a dull pain in the lower part of the belly. It is not constant, and is apt to pass for after-pains. The lochial discharge continues, and the secretion of milk is not checked. The pain at first, and usually during the whole course of the disease is slight, it is generally felt near the pubis, but it may also extend a little to one side, or toward the groin. Sometimes there is pain in the back, but frequently



there is none, unless when the patient sits up. The pain in the belly very soon is not perceived when she lies still, but is felt when she turns, or when pretty considerable pressure is made with the hand, or occasionally one or two sharp pains dart through the uterine region. There is no hardness to be felt, and the belly is not tender, but becomes a little full, the lochial discharge gradually diminishes, but does not of necessity stop, and the milk sometimes continues plentiful. There is considerable thirst, no appetite, and the sleep is disturbed. The pulse, which at first is very frequent, falls in a day or two to a 100, or varies from 90 to 108. The head is confused rather than painful, slight wandering pains may be felt in the belly or sides. The bowels are generally affected, being at first rather bound, afterwards loose or irregular, and the fæces dark, slimy, or foetid. Sometimes there is a degree of strangury. In the course of a fortnight, the pulse becomes slower, the appetite gradually returns, and these circumstances are preceded or accompanied with a slight discharge of blood from the womb, or of purulent matter by the rectum, or from the vagina. Sometimes the disease is much shorter in its course, being little more protracted than an ephamera, the symptoms yielding completely to the treatment; or they may be removed in so far, as that all fever and pain go off; but when the patient comes to rise, she feels a pressure like prolapsus uteri, which continues for many days or even weeks, so that she cannot stand, but has an instinctive desire to run to a seat. It is not easy to distinguish this state from prolapsus, except by examination. The uterus is felt in its proper altitude, but often the os uteri is turned a little to one side, and the vagina is not lax, but may be rather rigid: pessaries gives little or no relief. The complaint continues obstinate, preventing the patient from walking, though she is in good health, until a little purulent matter, or still more frequently, a little blood like the menses is discharged, and then she is almost instantly cured.

The treatment of this species of uterine inflammation consists in exciting early a free and pretty copious perspiration,

fomenting the belly, and opening the bowels with a smart purge. If the pains be more permanent, blisters may be necessary, and blood-letting, if early employed, is useful, but most cases recover without the use of the lancet, merely by cuticular and intestinal evacuation.

The more serious and extensive inflammation of the uterus, may be excited in consequence of rude management, or other causes. The disease usually begins about the third or fifth day after delivery, but it may take place at a later period. It is pointed out by a pain in the lower part of the belly, which gradually increases in violence, and continues without intermission, though it is subject to occasional aggravations. The uterine region is very painful when it is pressed, and it is a little swelled. There is, however, no general swelling of the abdomen with tension, unless the peritoneum have become affected. But the parietes are rather slack, and we can feel distinctly the uterus through them, to be hard and enlarged, and it is very sensible. There is also pain felt in the back, which shoots to the groins; and there is usually a difficulty in voiding the urine, or a complete suppression, or distressing degree of strangury. The situation of the pain will vary according to the part of the uterus first and principally affected. The internal parts also become frequently of a deep red colour, and the vagina and uterus have their temperature increased. The lochial discharge is very early suppressed, and the secretion of milk diminished or destroyed. Nearly about the same time that the local symptoms appear, the system becomes affected. The patient shivers, has head-ach, is often sick, and vomits bilious or dark-coloured fluid. The pulse very early becomes frequent, and somewhat hard, and the skin is felt to be hot. The tongue is white and dry, the urine high coloured and turbid, and if the bladder be affected, it may be suppressed. The vomiting in some cases continues, and the bowels are at first bound, but afterwards the stools are passed more frequently.

If the inflammation do not extend along the peritoneum, this disease is more easily cured, than other visceral inflam-

mations in the puerperal state. It may terminate favourably by a free perspiration, a diarrhœa, or a uterine hemorrhage; which last is the most frequent and complete crisis. If the pains abate, the pulse come down, and the lochia and secretion of milk return, we consider the patient as having the prospect of a speedy cure. But in many other cases the disease is more obstinate, the fever continues, the pulse becomes more frequent, but is full for a day or two, after which, it becomes small, the tongue is redder, but dry, the pain does not abate, and in some days shiverings take place, and the pain becomes of the throbbing kind. The face is pale, unless when the cheeks have a hectic flush; the urine, which was formerly high coloured, now deposits a pink-coloured sediment, in great abundance. The nights are spent without sleep, and the patient is wet with perspiration. After some time, matter is discharged from the vagina, or by the bladder or rectum, but oftenest from the rectum. The hectic symptoms continue for many weeks; and may at last prove fatal. Sometimes the disease early proves fatal, the pulse increasing in frequency, the tongue becoming very red, and the strength sinking; but even in this case, it will generally be found, that suppuration has taken place. Pus is contained often in the ovaria and tubes, and sinuses of the uterus. Mortification is an extremely rare termination. This is a fact, of which my dissections convince me, and it is farther confirmed by the opinion of Dr Clarke. Little or no serous effusion takes place into the abdomen.

This disease calls for the early use of the lancet, which is the principal remedy; and the quantity of blood which we take away, and the repetition of the evacuation, must depend on the constitution of the patient, the effects produced, and the period of the disease. If two or three days have passed over, the pulse may be full and frequent; but this is an indication that suppuration is going on, which will be ascertained by throbbing pains, &c. In this case the lancet is hurtful. Mild laxatives are also highly proper. Fomentations, sinapisms, and embrocations, are useful. Diaphoretics ought to be administered, such as the saline julap, with



the addition of antimonial wine and laudanum. This is the best internal remedy I think we can employ. Emollient clysters, or sometimes anodyne clysters give relief. In the suppurative stage, we must keep the bowels open, give light nourishment, apply fomentations, and allay pain with anodynes. When the matter is discharged, a removal to the country will be useful, and tonic medicines should be given.

Sometimes the round ligament suffers chiefly, and the patient complains of pain and tenderness at the groin, increased by pressure. The lower part of the belly is, after a little, swelled and uneasy. Fever attends this disease, and sometimes the stomach becomes irritable. It is often caused by hasty extraction of the placenta. It requires the early use of laxatives; and if the symptoms are violent, it is proper to take blood from the arm, and apply leeches to the groin, which should seldom be omitted. Afterwards we employ fomentations and blisters. If neglected, the disease may end in suppuration, or in a painful swelling, at the ring of the oblique muscle, which lasts a long time. This is sometimes removed by issues. Anodynes should be given, to allay irritation, and the strength must be supported under the fever, which resembles hectic.

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## CHAP. XV.

### *Of Peritoneal Inflammation.*

THE peritoneal lining of the abdomen, or the covering of the intestines, may be inflamed alone; or this disease may be combined with inflammation of the uterus.

Peritoneal inflammation may be caused by violence during delivery, or the application of cold, or the injudicious use of stimulants. It may not come on for three weeks after delivery, but it usually commences earlier than inflammation of the womb; and it may often be observed, that the pulse continues frequent from the time of delivery. It is preceded or attended by a shivering and sickness, or vomiting, and is marked by pain in the belly, which sometimes is very uni-

versal; though, in other cases, it is at first confined to one spot. The abdomen very soon becomes swelled and tense, and the tension rapidly increases. The pulse is frequent, small, and sharp, the skin hot, the tongue white and dry, the patient thirsty; she vomits frequently, and the milk and lochia are obstructed. Very soon, the belly becomes as large as before delivery, and is often so tender, that the weight of the bed-clothes can scarcely be endured; the patient also feels much pain when she turns. The respiration becomes difficult, and sometimes a cough comes on, which aggravates the distress. The bowels are either costive, or the patient purges bilious or dark coloured fæces. These symptoms are more or less acute, according to the extent to which the peritoneum is affected. They are, at first, milder, and are more protracted, in those cases where the inflammation begins in the uterus; and in such the pain is often not very great, nor very extensive, for some time. If the disease is to prove fatal, the swelling and tension of the belly increase, so that the abdomen becomes round and prominent, the vomiting continues, the pulse becomes very frequent and irregular, the fauces are aphthous, the extremities cold, and the pain usually ceases rather suddenly. The patient has unrefreshing slumber, and sometimes has delirium mite. The disease may be protracted for eight or ten days, or even longer. If the patient is to recover, the swelling does not proceed to a great degree; the pain gradually abates, the vomiting ceases, the pulse becomes fuller and slower, the breathing easier, so that the patient can lie better down in bed, and she can turn more easily. Sometimes this disease ends in suppuration, and the abscess points and bursts externally. Dr Gordon, in his treatise on puerperal fever, relates three cases of this kind. In one of these, the matter was discharged from the umbilicus, a month after the attack; in another, six weeks after delivery; and in the third, after two months, it came from the urethra. Similar cases have come under my own observation.

Upon dissection, the peritoneum is found in a state of high inflammation, but it is rare to find it mortified. A

considerable effusion of serous fluid, mixed with curdy substance, is found in the belly.

The patient is only to be saved by vigorous means, and great attention. If the pulse continue above a hundred in the minute, for twenty-four hours after delivery, there is reason to apprehend that some serious mischief is about to happen; and therefore, unless the frequency depend decidedly on debility, produced by great hemorrhage, &c. we ought to open the bowels freely, and give a diaphoretic. We must carefully examine the belly, and if it be full, or painful on pressure, or if the patient be inclined to vomit, we ought to open a vein, and use purgatives. I know that many are unwilling to bleed women in the puerperal state, and the condition of the pulse may seem to young practitioners to forbid it. But in cases of peritoneal inflammation, not connected with typhoid fever, I must strongly urge the necessity of blood-letting, at a very early period; and the evacuation is to be repeated or not, according to its effects, and the constitution of the patient. If she have borne it ill, and is not relieved, when it is used first, I apprehend that the case has not been simple peritoneal inflammation, but is puerperal fever. If she bear it well, and the pulse become slower and fuller, and the pain abate, we are encouraged to repeat it. I wish to impress on the mind of the student in the most earnest manner, the fatal consequence of neglecting blood-letting in this disease. How many women fall a sacrifice to the timidity or inattention of their attendant! The lancet is the anchor of hope: it may indeed be pushed too far; it may be used by young practitioners in cases of spasm, mistaken for peritonitis; but the error is safer than the contrary extreme, for of two evils debility is more easily removed, than inflammation. After the lancet has been freely used, if pain continue, leeches, or the scarificator may be applied to the most painful part. The bowels are to be opened freely with calomel, or some other purgative; and in an advanced stage of the disease, after effusion has taken place, we must employ purges alone, rather than blood-letting. Sinapisms and blisters are also proper. Digitalis has been given, either



to abate inflammation, or promote absorption, after effusion has taken place; but I have not found it useful. After effusion has taken place, and debility is produced, cordials, of which wine is the best, should be given, and anodyne clysters are to be administered.

Chronic, or slow inflammation of the peritoneum, is not very unfrequent, and may last for some weeks. It is attended with constant pain in some part of the abdomen, but it is not unbearable; the belly is tender, the pulse frequent, the thirst urgent, and often the mind is affected as in hysteria; or a train of hysterical symptoms supervenes, which may lead off the attention from the seat of the disease. It requires at first blood-letting, and then the frequent use of laxatives, with repeated blisters.

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## CHAP. XVI.

### *Of Puerperal Fever.*

PUERPERAL fever begins sometimes in an insidious manner, without that shivering which usually gives intimation of the approach of a serious malady. In other cases, the shivering is perceived, and varies considerably in degree, being either slight or pretty severe. The first symptoms, independent of the shivering, are frequency of pulse, and pain in the head, particularly over the eye-brows, and at the same time, or very soon afterwards, pain is felt in the belly. This is at first slight, but it presently increases; and in some instances, the abdomen is so tender, that even the weight of the bed-clothes is productive of distress. A general fulness, or swelling of the belly, then comes on, and it usually increases pretty rapidly, and may proceed so far as to make the patient nearly as large as she was before delivery; and in such cases, the breathing becomes very much oppressed: indeed, in every instance, the respiration is more or less affected; the free action of the abdominal muscles, which are concerned in that function, being productive of pain. The face is sometimes flushed at first, or the cheeks are suffused, but the countenance in general, is pale and ghastly, the eyes is without ani-

mation, and the lips and angles of the eyes are white. The whole features indicate exhaustion or great debility. Vomiting occasionally occurs at the very commencement, and in that case it is bilious. In the course of the disease, it sometimes becomes so frequent, that nothing will stay in the stomach; and towards the conclusion of the fever, the fluid thrown up is dark coloured, and frequently fætid. This is a symptom, which, so far as I have observed, always, if it do not proceed from a morbid structure, indicates in whatever disease it occurs, an entire loss of tone of that organ. But to proceed with the history: There is great dejection of mind, languor with general debility of the muscular fibres, and the patient lies chiefly on her back; or there is so much listlessness, that she sometimes makes little complaint. The skin is not very hot, but is rather clammy and relaxed. The tongue is pale or white at first, but presently becomes brown, and often aphthæ appear in the throat, or mucus is secreted, which excites a cough. The pulse, even at first, is very frequent, and is, at that period, fuller than in simple peritoneal inflammation, but it soon becomes feeble. The thirst is not always great, at least the patient is often careless about drink. The bowels are often at first bound; but afterwards, especially about the third day, they usually become loose, and the stools are dark, fætid, and often frothy. This evacuation seems to give relief. The urine is dark coloured, has a brown sediment, and is passed frequently, and with pain. The lochial discharge is diminished, and has a bad smell, or is changed in appearance, or gradually ceases; and it is observable, that the re-appearance of the lochia, if they had been suppressed, it is not critical. The secretion of milk stops, and the patient inquires very seldom about the child. In some cases, I have met with pleuritic symptoms. As the disease advances, the pulse becomes more frequent and weaker, or tremulous. In bad cases, the swelling of the belly increases rapidly, but the pain does not always keep pace with the swelling, being sometimes least, when the swelling is greatest, and in the end, it generally goes entirely off. The breathing becomes laborious, in proportion as

the belly enlarges. The strength sinks, the throat and mouth become foul, the stools are passed involuntarily, low delirium sometimes takes place, and the patient usually dies about the fifth day of the disease, but in some cases not until the fourteenth; in others so early as the second day.

This fever attacks generally on the second or third day after delivery, but it has occurred even after a week. The earlier it attacks, the greater is the danger, and few women recover who have the belly much swelled.

On dissection, there is found, in the abdomen, a considerably quantity of fluid, similar to that met with in peritonitis. The omentum and peritoneum are inflamed, but perhaps very slightly, and gangrene is unusual. The uterus is not more affected than the intestines. In some cases, the thoracic viscera are affected in a similar way.

It is most frequent, and most fatal, in hospitals. In private practice it is less malignant, though still very dangerous. It is sometimes epidemic, but I do not know that it has ever appeared, as a prevailing epidemic in this city, nor have I been able to trace the contagion from one woman to another. In hospitals, as well as in the private practice of individuals in other places, it has appeared as a contagious disease. There has been much dispute whether the contagion was one *sui generis*, or that of typhus or erysipelas, or hospital gangrene; or if the disease depended on some noxious state of the atmosphere, conjoined with the absorption of putrid matter. The disease appears to depend on inflammation of the peritoneum, conjoined with the operation of some debilitating poison, probably, in most cases, more or less contagious.

It is important to distinguish this disease from simple peritonitis, which may generally be done by attention. In puerperal fever, the abdominal pain is not the most prominent symptom. There is more despondency, debility, and head-ach; less heat of the skin, less thirst, and less flushing of the face. In the peritoneal inflammation, the pain in the belly usually increases rapidly after it begins, and the swelling increases along with it. Pressure gives very great



pain. The fever is inflammatory. Inflammation of the uterus has its proper symptoms.

This disease is dangerous, in proportion to the malignancy of the cause, and the situation of the patient. All writers agree, that in hospitals it is peculiarly fatal, and that few recover from it. In private practice, the disease is milder, but still it is most formidable. With regard to the best mode of treatment, there has been a great difference of opinion, which partly depends on giving the name of puerperal fever to different disorders<sup>1</sup>. I am sorry that I find it much easier to say, what remedies have failed, than what have done good. I have stated, that in peritoneal inflammation, blood-letting and laxatives are the principal remedies; but in this disease, blood-letting seldom does good, and often is hurtful. I am convinced, that if it is to be used at all, it must be very early, and that it ought not to be pushed far. If the symptoms of depression of strength, and the characters of puerperal fever, be very decided, we must not bleed; but if the debility be less obvious, if the pain and inflammatory symptoms be considerable, and the case has a mixed appearance, approaching to peritonitis, and we are called early, a vein may be opened; but if the pulse speedily become small, or the patient feel faintish, we must not continue the evacuation, and are upon no account to repeat it merely because the blood is buffy. Whether we bleed or not, it will be proper to begin the use of the bark, giving it as liberally as the stomach will bear, or administering it in the form of a clyster. Opiates, given freely, have the effect of abating irritation and pain, and of restraining immoderate diarrhoea, should that come on. Diarrhoea should not be allowed to continue long, and is always to be restrained, unless it evidently give relief, and the faeces be very foetid. In this case, diluents should be employed. If there be tenesmus, anodyne clysters should be given. If there be not, emollient clysters often give temporary relief. Should the bowels be costive, which is seldom the case indeed, a gentle laxative is to be given, which ought to be of the saline kind,

and will likely bring away dark coloured foetid stools. If the bowels have been formerly very open, but the diarrhoea have stopped naturally, or by the use of opiates, a gentle laxative or clyster should be given, if more than a day pass without a stool, as the accumulation of morbid fecal matter is equally hurtful with much purging. Vomiting is to be restrained by solid opium, and by an opium plaster applied to the region of the stomach : sometimes saline draughts are of service. Nausea has been supposed to indicate the necessity of an emetic ; but if no relief be obtained from natural vomiting, which most practitioners admit, I do not see that artificial vomiting can be useful, nor does experience support the practice. Fomentations, and anodyne frictions, sometimes abate the pain in the abdomen. The repeated application of blisters has been extolled by some, but I am much inclined to concur with Dr Clarke, in thinking, that they rather excite an injurious irritation. The strength should be supported by light nourishment, and a moderate proportion of wine, or other cordials. Digitalis and other diuretics have been given, to carry off the effused fluid, but they have no effect. Emetics and antimonials, I am afraid, do more harm in general than good. Upon the whole, we trust chiefly to tonics, in the cure of the puerperal fever ; we support the strength, and regulate the state of the alvine discharge, preventing accumulation of morbid faeces on the one hand, and restraining immoderate evacuation on the other. Most authors have laid down distinct and formal indications to be fulfilled ; but it is much to be doubted, if the means proposed be adequate to the effect intended to be produced ; or if all the parade of science has done more than shew, that, with the addition of remedies for removing particular symptoms, one class of practitioners have trusted to the lancet as the chief engine of cure, and another to the use of bark and cordials. Peritonitis is much more frequent than puerperal fever.

## C H A P. XVII.

*Of Swelled Leg.*

The swelling of the inferior extremity, in puerperal women, is usually preceded by marks of uterine irritation, and a tender state of the parts within the pelvis. About a fortnight after delivery, sometimes later, sometimes a little earlier, the patient complains of pain in the lower belly, increased by pressure, and occasionally has pain and difficulty in making water. The uterine region is somewhat swelled. The pulse is frequent, the skin hot, the thirst increased, and these symptoms are often preceded by shivering. Stiffness and pain are now felt in one of the groins, near the passage of the round ligament, or the exit of the tendon of the psoas muscle, or in some cases about the origin of the sartorius and rectus muscles. The pain is attended with swelling, and these two symptoms may proceed gradually down the limb; but more frequently, pain is felt suddenly in the calf of the leg, or at the knee, near the insertion of the sartorius muscle, and is most acute in the course of that muscle; it also darts down to the heel. Within twenty-four hours after the pain is felt, the limb swells, and becomes tense; it is hot but not red; it is rather pale, and somewhat shining. The swelling sometimes proceeds from the groin downwards; in other cases, it is first perceptible about the calf of the leg, and proceeds upwards. It generally procures an abatement of the pain, but does not remove it. On the contrary, the patient cannot move the leg, and it is tender to the touch. The pulse is very frequent, being often 140 in the minute, and generally is small and feeble, but sharp; the tongue is white and moist, the countenance has a pale chlorotic appearance, the thirst is considerable, the appetite is lost; the bowels are either bound, and the stools clay coloured, or they are loose, and the stools very foetid. The urine is muddy; the lochial discharge sometimes stops, or becomes foetid, in other cases is not at all affected. The nights are spent without sleep, and the patient perspires profusely.



All the parts within the pelvis are tender, and the os uteri is open, but not more painful when touched, than the sides of the vagina or the internal muscles.

The period at which the swelling reaches the acmé is various, but often it is accomplished in twenty-four or forty-eight hours. It seldom makes the limb above double its usual size. Generally in ten days, sometimes in even two or three, the febrile symptoms, swelling, &c. abate; but it may happen that they are protracted longer, and they do not go off entirely for some time. When they go off, the patient is left feeble, and the limb stiff, weak, and often for a time powerless. In the course of the cure, we frequently feel hard bumps in different parts of the limb, especially on its back and inside. These are not glands; some consider them as indurated lymph, others as muscular contractions. At the top of the thigh, the inguinal glands are often felt swelled, even at the beginning of the complaint; but in some cases, I have found them not at all affected.

If the skin be punctured, no serum is effused, at least not in the same way as in anasarca, and the swelling is not increased in a depending posture.

In some cases, the disease begins like rheumatism affecting the back and hip joint. Then the upper part of the thigh becomes painful and swelled, and next the calf of the leg suffers; sometimes the limb at first feels colder than the other.

In one or two instances, suppuration has taken place: mortification has also happened.

It is always a length of time before the patient recovers, for the swelling does not go soon entirely away, and the strength is long of returning. In some instances, the limb remains permanently swelled and feeble.

After one leg has been affected, and even before the complaint has completed its course there, the other may become diseased; and this has no influence on the progress of the first. The second attack is sometimes the worst of the two, owing, perhaps, to the previous debility. A coldness is often felt in the second leg, before the paroxysm comes on, and

pain in the belly precedes the attack. The first leg may be a second time attacked.

This is not generally a fatal disease, but it is tedious, and is often accompanied with hectic symptoms. Death, however, may be caused by suppuration or gangrene; or by exhaustion, proceeding from the violence of the constitutional disease; or from exertion made by the patient, which has sometimes proved suddenly fatal.

The production of this disease does not seem to depend on the circumstances of the labour, for it appears both after easy and difficult deliveries. Those who give suck, and those who do not, the strong and the weak, are affected by it. It has succeeded an abortion, or suppression of urine. I am inclined to consider the cause to be a morbid state of the parts within the pelvis, which sometimes produces merely a stiffness and swelling at the passage of the round ligament. Puzos and Levret consider the disease as proceeding from a depot of the milk. Most modern writers attribute it to an affection of the lymphatics, which are ruptured, or have their circulation interrupted by swelling of the inguinal glands. Dr Hull considers the disease as an inflammatory affection, suddenly succeeded by effusion. I refer, for a view of the different opinions, to his *Treatise on Phlegmatia Dolens*. The disease seems to depend partly on inflammation, and partly on nervous irritation; and the cure consists in lessening the one, and allaying the other.

The treatment naturally divides itself into that of the limb, and that of the constitution.

Our first object is to check the disease within the pelvis. For this purpose, leeches ought to be applied to the groin, and we should immediately open the bowels with a purgative. A small blister should then be applied to the groin, and afterwards cloths, wet with tepid solution of acetate of lead, or with warm vinegar. These means may prevent the swelling, or render it milder. If the disease have already taken place in the limb, fomentations, and gentle friction, with anodyne balsam, or camphorated oil, will be useful. The bowels should still be kept regular, but the patient is not to be

purged. Opiates are useful, to allay irritation. When the acute symptoms are over, we endeavour to remove the swelling, and restore the tone of the part, by friction with camphorated spirits, and the use of the flesh brush, and a roller applied round the limb. The liberal use of solution of cream of tartar is also, in many cases, of service. If the disease threaten to be lingering, small blisters may be applied to the groin. If much weakness of the limb remain, the cold bath is proper, or sometimes a bath of warm sea-water.

Besides these means, we must also employ remedies for abating the fever, and constitutional affection. At first we use saline draughts, but these are not to be often repeated, and must not be given so as to procure much perspiration. In a short time they should be exchanged for bark, sulphuric acid, and opiates, which tend to diminish the irritability. In the last stage, we give a moderate quantity of wine. When the pain shifts like rheumatism, bark, with small doses of calomel, are useful. If the uterine discharge be foetid, it is proper to inject tepid water, or infusion of chamomile flowers into the vagina. Exposure to cold, during the first stage of recovery, may cause a relapse. The treatment thus consists chiefly in palliating symptoms, and supporting the strength. I cannot, however, agree with those who, in the very outset of the disease, give wine liberally, as there certainly does, at that time, exist an inflammatory tendency. The diet should be light and nutritious.

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## CHAP. XVIII.

### *Of Paralysis.*

SOME women, after, delivery, lose for a time the power of the inferior extremities, although they may have had a very easy labour. This paralysis may exist in different degrees, and in some cases the muscles are painful. Sometimes it is attended with retention of urine. It is not accompanied with any cephalic symptoms. In general, the disease wears off in a few weeks. Friction, the shower-bath, tonics, and



gentle exercise on crutches, are the means of cure. The bowels are also to be kept open.

After a severe or instrumental delivery, the woman may complain of excessive pain about the loins and back, attended with lameness, or even palsy. This is sometimes a very tedious complaint, but usually it is at last removed. The tepid bath, with anodyne embrocations, relieve the pain; and at a more advanced period, sea bathing is proper.

Hemiplegia may attack women in the puerperal state, as well as at other times. It proceeds from the same cause, and requires the same treatment, as usual. If death takes place, blood is found extravasated in the brain.

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## CHAP. XIX.

### *Of Puerperal Mania and Phrenitis.*

ALL women, in the puerperal state, are more irritable, and more easily affected, both in body and mind, than at other times, and some even become delirious. The period at which this mental disease appears is various, but it is seldom if ever sooner than the third day, often not for a fortnight, and in some cases not for several weeks after delivery. It usually appears rather suddenly; the patient awakening, perhaps, terrified from a slumber, or it seems to be excited by some casual alarm. She is sometimes extremely voluble, talking incessantly, and generally about one object, supposing, for example, that her child is killed, or stolen; or, although naturally of a religious disposition, she may utter volleys of oaths, with great rapidity. In other cases, she is less talkative, but is anxious to rise and go abroad. It is not, indeed, possible to describe the different varieties of incoherence, but there is oftener a tendency to raving than melancholy. She always recognises surrounding objects, and either answers any question put to her, or becomes more exasperated by it. She can by dint of perseverance, or by proper management, be for a time interrupted in her madness, or rendered in some degree obedient. In some instances, she

reasons for a little, pretty correctly on her insane idea. The eye has a troubled appearance, the pulse when there is much nervous irritation, or bodily exertion is frequent, but it is not in general permanently so, though it is liable to accelerations; the skin is sometimes rather hot, the tongue white; the secretion of milk is often, but not always diminished, and the bowels are usually costive. In some instances the patient recovers in a few hours, in others the mania remains for several weeks, or even some months; but I believe it never becomes permanent, nor does it prove fatal, unless dependent on phrenitis. Blood-letting has been advised in this disease; but I agree with those who consider it as hurtful, or at least as useless. The best practice, I think, is to open the bowels, keep the surface gently moist, by means of saline julap, and allay irritation with liberal doses of hyocyamus and camphor. Blisters have by some, for whose opinion I have much regard, been considered as useless, or detrimental; but I am confident I have seen them do good, after they had discharged freely. Opium is a very doubtful remedy; it oftener makes the patient restless, than procures sleep; but in the wane of the disease, it does in some cases agree with the patient. The mind is to be managed with prudence and attention, and the patient kept as much as possible from exerting herself.

Some are peculiarly liable to this disease after delivery, in consequence of the irritable state of the nervous system at that time. In such cases, the patient must be carefully watched after parturition. Every irritation must be removed, every source of alarm or agitation obviated, and the camphorated julap with gentle laxatives will be proper remedies, these being the most powerful means of diminishing the excessive irritability of the nervous system. The diet is also to be regulated. If the patient do not sleep well, hyocyamus should be given.

Melancholly usually comes on later than furious delirium. The disease differs nothing in appearance and symptoms from melancholy madness occurring at other times. It is obstinate, but generally goes off after the child is weaned, and

the strength returns. It is therefore proper to remove the child, and send the patient to the country as soon as possible. In some instances, both kinds of madness seem to be dependent on a morbid irritation, such as inflammation of the mamma, &c. Here our attention must be directed to the cause.

Inflammation of the coverings of the brain usually appears still earlier than delirium, from irritation. It may be caused by determination of blood to the head, or preternatural irritability of the sensorium, or may occur in consequence of a constitutional tendency to mania. It must be distinguished from puerperal delirium which is seldom dangerous, whilst this is a most fatal disease. It appears within the second or third day after parturition. The pulse continues frequent from the time of delivery; and after the attack, rises perhaps above 120 in the minute; the patient does not sleep, but is watchful, and has intolerance of light; she soon complains of confusion, rather than pain in the head; hears very acutely, and speaks in a hurried manner, but when questioned early, often says she is quite well. Then furious delirium comes on; she pays no regard to, or at least does not seem to recognize objects around her, and cannot be made to answer any questions, or understand any argument of persuasion. She usually hurries from one subject to another; the eyes move rapidly, are sparkling and wild, and very sensible to the light. The lochia are not suppressed, nor are the bowels bound, but the secretion of milk ceases. In three or four days, the patient sinks into a low comatose state; the extremities become cold, the breathing laborious, and sometimes convulsions precedes death. This disease requires the prompt and early use of the antiphlogistic treatment, general and local blood-letting, the use of purgatives, and the application of a blister to the scalp. The inflammatory symptoms being subdued, the delirium abates, or goes off, by the use of remedies formerly pointed out.



## CHAP. XX.

*Of Bronchocele.*

SWELLING of the thyroid gland takes place, so much more frequently after parturition, than under other circumstances, that it may with propriety be noticed here. It appears within a few days after delivery, and is often attributed to exposure to cold. In other cases, the woman feels during labour, as if something had given way about the throat. It may remain long in an indolent and stationary state, being productive either of no material inconvenience; or only of a slight difficulty of swallowing. In other instances, it augments in size, and becomes dangerous from its pressure on the neighbouring parts; or it inflames, forms a large abscess, and bursts. Enlargement of the left lobe is more dangerous than that of the right.

Various remedies have been employed, such burnt as sponge; calomel, muriate of lime, &c. but these have seldom much effect. Repeated blisters, and long continued friction, are more useful. If the tumour threaten to enlarge, which it often does, after every succeeding pregnancy, or even independent of gestation, it has been proposed to extirpate the tumor, or to tie the arteries going to it. If there be a tendency to suppuration, it ought to be encouraged, and treated on general principles.

## CHAP. XXI.

*Of Diarrhœa.*

IF the patient have been costive before delivery, large masses of fæces may come down afterwards, producing violent pains in the belly, piles, tenesmus, or uterine hemorrhage; or the same cause may excite diarrhœa with the passage of scybalæ. Both states require the use of gentle laxatives. Diarrhœa may also occur without previous costiveness; the stools are then fœtid or bilious. In this case the diet is to

be strictly regulated ; gentle laxatives are to be first given to evacuate the offensive matter, and then opiates are to be immediately resorted to. If neglected, great weakness, uterine hemorrhage, or other serious consequences may be produced. When it is accompanied with bilious vomiting, and cramps or spasms, opiates are the principal remedy, and these must, if vomited, be given in the form of clysters.

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## CHAP. XXII.

### *Of Inflammation of the Mamma, and Excoriation of the Nipples.*

INFLAMMATION of the mamma may take place at any period of nursing, but is most readily excited within a month after delivery. It may be excited by the direct application of cold, retention of the milk in consequence of sore nipples, mechanical injury, or it may occur in that febrile state, called weed. In general, the inflammation, however extensive it may afterwards become, is at first confined to a small spot. It may take place in the cellular substance alone, or it may affect the gland ; it may be attended with much general swelling of the breast, or the tumor may be very circumscribed ; it may run its course rapidly, or very slowly ; and when abscess forms, and the integuments burst, we may have matter alone discharged, or there may be a slough of considerable magnitude found within the abscess. This proceeds from the destruction of one or more of the glands, which if the inflammation run high, do not suppurate but die. Usually, there is a considerable degree of fever attending the complaint, and the pain is often severe, especially when the breast is extensively affected. It is a very difficult thing to prevent this inflammation from ending in suppuration. It is to be attempted, however, by purgatives, and the application of cloths wet with pretty strong solution of acetate of lead, which, however, ought not to be cold, as that might excite shivering ; or we apply a tepid saturnine poultice. If there be only a little diffused

fulness with some degree of pain, gentle friction with warm oil is useful. If the breast be distended with milk, it will be proper to have a little taken away occasionally, provided this can be done easily, and without increasing the pain. Our object in doing so, is to diminish the tension, and prevent farther irritation from accumulation in the vessels. The breast is also to be carefully supported, and indeed the patient will be easiest in bed. When the pain becomes throbbing, a warm bread and milk poultice is proper to assist the suppurating process. After matter is formed, it ought to be freely let out, by an opening of sufficient size, provided there be no appearance of the abscess bursting soon of its own accord. This prevents insinuation of matter in the cellular substance of the breast. If the puncture be followed by a troublesome oozing of blood from the wound, dry lint and compression must be used. In one instance, I knew the hemorrhage prove fatal. After the abscess bursts, or is opened, there is for some time a discharge of purulent matter, which frequently is mixed with milk; then the surrounding hardness gradually abates. The poultice may be continued for several days, as it promotes the absorption of the indurated substance; but if it fret the surface, and encourage a kind of phagedenic erosion, it is to be exchanged for mild dressings. A little fine lint is to be applied on the aperture, but not so firmly as to confine the matter; and over this, a cloth spread with spermaceti ointment; great attention is to be paid to the evacuation of the matter, and the prevention of sinuses.

In some instances the milk soon returns, and the patient can nurse with the breast which was affected, but more frequently it does not, and the child is brought up on one breast. It may even be requisite, if the fever and pain be great, and the secretion of milk much injured, to take off the child altogether.

If the management be negligent, or the constitution bad, it sometimes happens, that extensive suppuration, or numerous abscesses take place. The breast becoming altogether considerably diseased, and the discharge is very fetid. In



such cases, hectic fever, and great debility are induced. It is in general proper to remove the patient to the country, and give bark or tonics internally, with nourishing diet and wine. Sinuses must be laid open from the bottom, or counter openings must be made, and the sores dressed according to the general rules of surgery. Even although there be not much ulceration or any appearance of scrophulous induration, the strength may, from an extensive abscess, or protracted sore, be much diminished, and hectic induced, which is to be removed by the means commonly employed, or already pointed out.

Sometimes, although the abscess heals readily, and have been small, an induration remains, while either may continue long indolent, and cause apprehension respecting future consequences, or it may occasion a relapse. It is to be removed by gentle friction with camphorated spirits three times a day, and the application in the interval of cloths wet with camphorated spirits of wine, with the addition of a tenth part of acetum lythargyri. In more obstinate cases, mercurial friction, or a gentle course of mercury may be tried, but I cannot speak with any confidence of the effect. The bowels should always be kept open.

After an abscess heals, it is not uncommon for the breast to swell a little at night from weakness, and the same cause renders a relapse easy. It is therefore proper to invigorate the system, and defend the breast for some weeks more carefully than usual from cold. When a relapse takes place, especially if the patient be not nursing, the tumor is sometimes pretty deep or indolent, is for a long time hard to the feel, and gradually extends more through the breast, forming a pretty large substance, not unlike a schirrous or scrophulous gland. But during this time, suppuration is slowly going on, though there may be little pain. At last a more active change takes place, the pains increase, becomes throbbing, the skin red, and, finally, the abscess bursts. This state requires the application of warm poultices and hot fomentations.

Excoriation of the nipple is a very frequent affection,

and often excites that disease we have just been considering. The ulcer may be extensive, but superficial; or it may be more circumscribed, but so deep as almost to divide the nipple. When the child sucks, the pain is severe, and sometimes a considerable quantity of blood flows from the part. In some instances, an aphthous state of the child's mouth excites this affection; in others, excoriation of the nipple affects the child. A variety of remedies have been employed. Spirituous, saline, and astringent lotions have been used previous to delivery, with a view of rendering the parts more insensible; they have not always that effect, but they ought to be tried. When excoriation takes place, fifteen grains of sulphate of zinc, dissolved in four ounces of rose water, form a very useful wash, which should be applied frequently. Solutions of sulphate of alumine, acetate of lead, sulphate of copper, nitrate of silver, &c. in such strength as just to smart a little, are also occasionally of service; and it is observable, that no application continues long to do good. Frequent changes, therefore, are necessary. The nipple should always be bathed with milk and water before applying the child. When chops take place, dressing the part with lint, spread with spermaceti ointment, is sometimes of use. A combination of white wax, with fresh butter or melted marrow, with or without vegetable additions, form popular applications. Stimulating ointments, such as ungu. hyd. nit. diluted with axunge, are sometimes of service; or the parts may be touched with burnt alum.

It is often useful to apply a tin case over the nipple, to defend it, or a chalk cup, which absorbs the discharge, or broad rings of lead or ivory. It is also proper to make the child suck through a teat fixed on a metallic nipple, that the irritation of its tongue or mouth might be removed. This often is of great service, but it does not always succeed; and some children cannot suck through it. The assistance of a nurse to suckle the child through the night is useful. But although the nipples ought to be saved as much as possible, yet if we keep the child too long off, or permit the breast to become much distended, inflammation is apt to

take place. When all these means fail, it is necessary to take off the child, as a perseverance in nursing exhausts the strength, and may excite fever. The part then heals rapidly.

Venereal ulceration of the nipple or areola, accompanied with swelled glands in the axilla, and a diseased state of the child's mouth, require a course of mercury.

It may be proper, before concluding this chapter, to add some remarks on causes disqualifying a woman from nursing. If the nipple be very flat, and cannot by suction be drawn out, so that the child can <sup>not</sup> get hold of it, the woman cannot nurse. A glass pipe, however, frequently used, sometimes remedies this defect. A deficiency of retentive power, so that the milk runs constantly out, is another disqualification, and it is not easy to find a remedy. When the milk disagrees with the child, having some bad quality, we are also under the necessity of employing another nurse. If the mother be very delicate, or be consumptive, or affected with obstinate melancholy, or have her eyes much inflamed, or the sight injured by nursing, or if the secretion be very sparing, she must give up nursing. Some delicate women suffer so much from nursing, that chlorotic, or phthisical symptoms are induced. In this case, she must take off the child. Opiates are useful at bed-time, to procure sleep, and the bowels are to be kept open. Many women, after delivery, are subject to disorders of the alimentary canal, especially diarrhœa and worms. These impair the health, and diminish the secretion of milk. They are to be treated with the usual remedies. Anasarca, jaundice, erysipelas, &c. may also occur in the puerperal state, and prevent nursing. The ordinary methods of cure are to be employed.

When a woman weans a child, or from the first does not suckle it, it is usual to give one or two doses of some purgative salt, by way of lessening the secretion of milk. The secretion is also checked by keeping off the child; but if the breasts be very much distended, so much must be taken away occasionally, by suction, or milking the breast,



or applying a warm glass bell, as relieves the feeling of tension or pain. If this be neglected, inflammation may be excited.

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## CHAP. XXII.

### *Of the signs that a woman has been recently Delivered.*

WE discover that a woman has been recently delivered, by finding that the external parts are relaxed, and redder, or of a darker colour than usual. There is a sanguineous or lochial discharge. The uterus is enlarged, and has neither the shape of the gravid nor unimpregnated uterus; the cervix is indistinct, and the os uteri is nearly circular, and will admit two or more fingers. The abdomen is prominent, and the integuments relaxed, wrinkled, and covered with light coloured broken streaks. The breasts are enlarged, have the areola very distinct, and contain milk; but it is possible for this secretion to take place independently of pregnancy.

By examination per vaginam, within a fortnight or three weeks after delivery, the uterus may still be felt larger than usual, its lips softer, and capable of admitting the point of the finger without much difficulty. The milk at this period will not have left the breasts, which are firm, and have a dark areola round the nipple. A question here occurs. May not all these appearances take place merely from hydatids? I reply, that hydatids certainly may produce the same effects with gestation, because they do very frequently spring from conception. It is, however, very rare for the belly to be enlarged to the same degree as in the end of pregnancy, and when the mass is expelled, as it is soft, the perineum cannot be injured. If then it can in a criminal case be proved, that the woman had the belly greatly enlarged, and if afterwards she is found with the breasts containing milk, the uterus large, and its mouth soft and open, and part of the perineum torn, or the fourchette torn, there can be little doubt that she has born a child. Other circumstances may

also concur in confirming the opinion of the practitioner; as, for instance, if the patient give an absurd account of the way in which her bulk suddenly left her, ascribing it to a perspiration, which never in a single night can carry off the great size of the abdomen in the end of a supposed pregnancy.

Very contradictory accounts have been given by anatomists, of the appearance and size of the uterus, when inspected at different periods, after delivery. If the woman die of hemorrhage, or from any cause destroying her, soon after delivery, the uterus is found like a large flattened pouch, from nine to twelve inches long. The cavity contains coagula or a bloody fluid, and its surface is covered with remains of the decidua. Often the marks of the attachment of the placenta are very visible. This part is of a dark colour, so that the uterus is thought to be gangrenous, by those who are not aware of the circumstance. The surface being cleaned, the sound substance of the womb is seen. The vessels are extremely large and numerous. The fallopian tubes, round ligaments, and surface of the ovaria, are so vascular, that they have a purple colour. The spot where the ovum escaped, is more vascular than the rest of the ovarian surface. This state of the uterine appendages continues until the womb has returned to its unimpregnated state.

A week after delivery, the womb is as large as two fists. At the end of a fortnight, it will be found about six inches long, generally lying obliquely to one side. The inner surface is still bloody, and covered partially with a pulpy substance, like decidua. The muscularity is distinct, and the orbicular direction of the fibres round the orifice of the tubes very evident. The substance is whitish. The intestines have not yet assumed the same order as usual, but the distended cæcum is often more prominent than the rest.

It is a month at least, before the uterus return to its unimpregnated state.

We know that the woman has had a recent miscarriage, by the state of the breasts, the sanguineous discharge from the vagina, the size of the uterus, and the softness and di-

lation of its mouth. If the woman die, the womb is found enlarged, its inner surface covered with the decidua, or maternal portion of the placenta. The vessels are enlarged, the tubes and ligaments very vascular; the calyx of the ovum is bloody. This, at a more advanced period, forms a kind of cicatrix, or a dusky yellowish body, called corpus luteum. This mark may exist, although the woman have not born a child, for the ovum may be blighted, perhaps even in the ovarium. It has been conjectured by some, that it may be produced even without sexual intercourse, but this point I cannot determine. I apprehend, however, that in such cases, the marks are not real corpora lutea; they have not ever been injected.

These appearances during life, or after death, which occur from a miscarriage, may also arise from the expulsion of hydatids, which usually are produced by the destruction of an ovum, in which case, even a distinct corpus luteum may be discovered.

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## BOOK IV.

### Of the Management and Diseases of Children.

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#### CHAP. I.

##### *Of the Management of Children.*

#### SECTION FIRST.

WHEN a child is born, the first thing to be done is to ascertain if it breathe or be alive. If it cry or breathe vigorously, then it may be safely separated from the mother\*.

\* Dr Denman, from observing that some children, after they had begun to breathe, had respiration checked, and died after the cord was tied, advises, that the ligature should never be applied till the pulsation cease. But when



This is done, by tying the navel-string about half an inch from the navel; another ligature is applied an inch nearer the placenta, and the cord is divided between these with a pair of scissars. In some countries, the division is made with a sharp flint, in others, by means of fire. The necessity of applying a ligature has been denied by different practitioners; but it has sometimes been found, that when the ligature had become slack, a considerable quantity of blood was lost, and even fatal hemorrhage has taken place.

When a child does not breathe soon after it is born, it is not always easy to say whether it is alive, for we have, at this time, no criterion of death except putrefaction; and, therefore, it behoves us always, unless this mark be present, to use means for preserving the child, by which some have been saved, after being laid past as dead. Children may be born apparently dead, in consequence of the head having remained long in the pelvis, or having been squeezed in a deformed pelvis; or owing to the cord having been compressed, either during the process of turning and delivering a child, or from its having descended before the presenting part of the child, or being so situated during labour, as to be compressed by the uterus. Some children die, owing to the head being born, covered with the membranes, some time before the body. This is the consequence of inattention, for, if the membranes be removed from the face, there is no risk of the child. In whatever mode children are still-born, the effect is referable, either to compression on the cord, first suspending, and then destroying animation; or to pressure on the brain; or to a state of insensibility and feebleness, preventing the action of respiration from taking place after birth.

In determining on our treatment of still-born children, our first object ought to be, to ascertain if the circulation be still going on in the cord.

If the child is vigorous and cries lustily, there is no occasion for delaying so long: nor have I ever known any bad effect result from this practice. It has been supposed, that as long as pulsation continued, the function of respiration was imperfect; but it is not so: the pulsation depends more on the continuance of the vitality or action of the placenta, than on the state of the lungs.

If the pulsation have stopped, no good can accrue from allowing the child to remain connected to the mother. The cord is to be immediately separated, and means used, as shall immediately be mentioned, for the induction of respiration.

If pulsation continue, the child is not in danger from want of respiration, for the foetal mode of living is continuing. The cause of stillness, then, is most likely a kind of syncope, or torpor, which prevents the action of respiration from being established; or it may be from compressed brain. In both cases, the skin is purple, from the blood not having been arterialised, and we have no mark of distinction till respiration begin. It is very common, in the first case, for the child to be still for a minute or more; then it makes a slight sob, and breathes low, with a sound of fluid in the throat; and then, of a sudden, respiration becomes perfect. In the second case, respiration, after it begins, continues longer oppressed, and may perhaps stop, the child dying in a short time.

When the cord pulsates at the time of birth, we are never to be rash in dividing it. It is of importance to keep up the foetal circulation, till the new mode of acting can be established, and we ought not completely to divide the cord in such cases till pulsation stop; because, if respiration should flag, we have the placenta as an auxiliary, if the connection still exist, and the pulmonary action being suspended, the foetal mode will continue, and support life till respiration become vigorous; for the two modes of changing the blood are not incompatible. Pulsation will no doubt at length stop, either from the heart of the child stopping, or the placenta being detached from the uterus, and its function being lost; but as long as pulsation continues, and the child does not breathe perfectly and regularly, no ligature should be applied. If, however, respiration do not begin, we are to open with a lancet or scissors, one of the umbilical arteries, from which blood spouts in a small stream; and, in a short time thereafter, breathing commences. If it should not, some method must be adopted for exciting res-

piration, such as wrapping the child in warm flannel whilst it is still in bed; friction, especially over the thorax, with the hand, or strong spirits; applying spirits to the nostrils with a feather; or giving a gentle concussion to the body, as, for instance, by slapping the bottom. But the most effectual remedy is inflating the lungs, by blowing either through the barrel of a quill, or applying the mouth directly to the child's mouth, at the same time that the nostrils are held, and the cartilages of the trachea pressed gently back to obstruct the œsophagus. The attempt at inflation is to be alternated with pressure on the thorax, to force the air out again. If, by this time, the pulsation have stopped in the cord, and the child do not recover, the cord is to be divided, for connection with the placenta is useless after the circulation stops. The cord is not to be tied, but only a loose ligature put round it; then it is to be divided, and the child removed to the fire, or put in warm water, and the artificial respiration sedulously continued. An injection is also to be administered; and if electricity could be employed, there is ground for thinking that it would be beneficial. Should the child, by these means, or after a longer time, begin to breathe, a little blood will most probably issue from the cord, and the quantity will increase. If this seem to assist the breathing, and make the child more active, it is to be permitted to proceed to the extent of two or three teaspoonfuls; but if it do not manifestly produce a good effect soon, it is to be stopped with a ligature, that it may not throw the child back in a state of inaction. Even when it is of service, it must be kept within bounds, otherwise dangerous debility will be the consequence\*. It will be chiefly useful when the breathing does commence, but is slow and oppressed, with stupor, indicating affection of the brain.

If the shape of the head be much altered, it has been proposed, whilst other means are employing, to attempt slowly and gently to press it into a more natural shape, but of the good effect of this I cannot speak from my own experience.

\* It is occasionally of service, in weakly performed respiration, to give some gentle cordials or stimulants.



In footling cases, it has been supposed, that extension of the spine was a cause of death, but this, I apprehend, is seldom the case.

It often is desirable to know, whether a child has been born alive, and destroyed afterwards; but the signs are extremely uncertain. When, therefore, the life of the mother is at stake, we must be very circumspect in forming our opinion. If the lungs be solid and sink in utero, the child certainly has not breathed; and although respiration may, from the first, be prevented by the midwife, it cannot by the mother. If the head be much misshapen, there is additional ground for believing the child to have been still-born, and if clothes have been made for the infant, it is to be presumed, that the mother intended to have preserved it. When, on the other hand, the child has a healthy look, and has been recently born, the lungs swim in water, and their air-cells universally contain some air, giving a frothy appearance to the mucus squeezed out of them, there is no doubt that the child has breathed. But we cannot from these circumstances say, that it has been intentionally deprived of life. Some corroborating facts must be necessary to fix this point, such as the birth having been concealed, and no preparation made for preserving the infant; the cord being untied, by which it has been allowed to bleed to death; or its being cut longer or shorter than would have been done by a midwife, marks of violence on the child, with the total want of all exculpatory evidence.

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When the child has not been recently born, or is putrid, the lungs are also putrid, and contain air, although the child have never breathed. They swim in water, and the investing pleura is emphysematous.

#### SECTION SECOND.

After the child is separated from the placenta, it is to be wrapped up in a piece of soft flannel called a receiver, and given to the nurse. Next, the soft white incrustation, which generally covers the skin, is to be gently and delicately removed, by ablution with tepid water, and the use of a

sponge, and sometimes of a little soap. It is not necessary to remove every part of this, nor make such attempts as will fret the skin; but in every instance, and especially if there be reason to suspect that the mother has had gonorrhœa or chancre, the surface should be washed. It is also customary, with many nurses, to bathe the body, or at least the head, with spirits, a practice which can serve no useful purpose, but may be attended with mischief. The child being dried, it is usual to wrap a bit of soft rag round the remains of the navel string, and retain this by means of a bandage brought round the belly. It is alleged, that this is necessary to prevent umbilical hernia; but hernia does not take place because the child is not bandaged, but because the umbilicus is unusually wide; and in those countries where no compress is used, hernia is not a frequent complaint. A tight bandage produces pain, difficulty of breathing, and other deleterious effects. The only purpose to be derived from a bandage is to retain the rag, which is, for the sake of cleanliness, applied round the cord.

It was at one time the practice to wrap the child very tightly round the whole body, and to stretch both the arms and legs, whilst the head was secured by tapes, passing from the cap to the body. A more easy method is now adopted, and it seems to be agreed upon, that the more simple and loose the dress is, the more comfortable will the child be. Nurses are peculiarly afraid of the head being cold, and therefore are apt to keep it too warm. In summer one cotton cap, I believe, is sufficient to preserve the heat, but in winter an under cap may be added, but neither of these ought to be secured by pins. Soft tapes are preferable, for this and every other part of a child's dress. The rest of the clothing consists of a short shift and a wrapper of fine flannel, which is better for a week or two than the separate pieces of dress employed by many, and which add to the time and trouble of shifting the child. All children cry when shifted and dressed, therefore the shorter and simpler that the process can be made, the better. Last of all, a cloth is to be applied, to receive the feces or urine, and this

is to be removed the moment it is soiled. By attention, a child may very early be taught to give indication when he wishes to void the urine or fæces, and can then be held over a pot or bason. It is proper to encourage the child to use these at regular intervals. Children should have their bottom and thighs washed and wiped dry, always after soiling themselves. The whole body ought likewise to be regularly washed, morning and evening, with a sponge and water, at first rather tepid, but soon brought to be cold, at least of the temperature that cold water has in summer. But although this is a general practice, yet some children do not agree with it, being languid, cold, and pale, after being washed, and these ought to have the water warmed a little. Plunging the child into cold water, is perhaps, in this country, for some weeks, rather too violent a shock, but about the third month, it will be proper to do so daily.

The temperature in which children are kept, should be such as neither to increase nor diminish the natural heat of the surface. The child in utero is placed in a temperature of about 96 or 98 degrees; but its power of generating heat is probably much less than after birth. The heat of the room, and the quantity of bed-clothes, should be nearly such as would be agreeable to a healthy adult. Depressing heat is to be avoided on the one hand, and exposure to cold on the other. The apartment should be well ventilated, but the infant ought not to be exposed to the open air, for nearly a month in winter, as it is apt to produce convulsions, or catarrh, with fever, or bowel complaints.

#### SECTION THIRD.

It is customary to give some food before the child be applied to the breast, and very frequently medicine also, such as salt, magnesia, or manna, to purge off the meconium. The absolute necessity of either of these practices may perhaps be questioned, especially if the mother be able to suckle at the usual time. A little milk and water is at all events sufficient; and with respect to laxatives, I believe that they are seldom necessary. If, however, the meconium do not



come freely away, and the child have no stool in twelve or sixteen hours, or seems to be oppressed, or troubled with pains, a little manna may be given with much advantage; but generally the milk which is first secreted, called colostrum, is sufficiently powerful. When the bowels begin to act, and the bile is plentifully secreted, it is usual for the child in consequence of absorption of bile, or perhaps of meconium, to have a yellow tinge on the skin which is called the gum. This is sometimes attended with a drowsy state. If it require any medicine at all, it is a gentle laxative.

All children are intended to be brought up on the breast, and they ought to be applied early, generally betwixt twelve and twenty-four hours after birth. Some mothers, however, cannot, and others will not, suckle \* their children, but employ another nurse<sup>1</sup>, or bring the child up on the spoon. If the latter mode is to be adopted, it is necessary to determine the proper diet, and the best mode of giving it.

It is evident that the diet which will be most suitable for an infant, is that which most nearly resembles the mother's milk. It is not sufficient that we merely give it milk, it must be milk similar to that of the human female. It is certain, that the lacteal secretion of each species is best fitted for the young of that species; and we know that there is a great diversity both in the flavour, and proportion of the component parts, of different milk. Yet, in many cases, the milk of one animal will agree with the young of a very different species. Thus a levcet has been suckled by a cat. Milk consists of cream, curd, and whey; and, the whey the greatest portion of which is water, is the only part that becomes sour. The quantity of cream is greatest in ewe's milk, next in that of women, the goat, the cow; and then the ass and the mare. The proportion of whey is greater in the milk of mares and women, than of the cow; or the sheep. With regard to the caseous part, it is greatest in the milk of the sheep, the goat, the cow, the ass, the mare, in the order in which they stand;

\* Van Helmont, and after him, Browzet and others, have advised, that children should not be brought up on the breast, but fed on asses and goats milk, or a panado made of bread boiled in small beer, and sweetened with honey.

cream  
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could  
be  
whey  
part  
of milk

and it is little in that of women. Sugar again is most abundant in the milk of the mare and women, and less so in that of the goat, the sheep, and the cow. Women's milk contains more cream, than cows' milk, yet no butter can be made from it. It contains much whey, and yet it scarcely ever becomes sour by exposure to air, and does not pass either to the vinous or putrefactive fermentations. Acids do not coagulate human milk.

From these remarks it follows, that if a child is not suckled, the best food will be milk, resembling that of women, and the nearest is asses; but as this cannot always be procured, we must change that of cows, so as to diminish the proportion of curd, and increase that of sugar and cream, which is done by adding an equal quantity of water, or sometimes of new made whey, a sixth part of fresh cream, and a little sugar. This is to be mixed just as it is required, for by standing it acquires bad properties. It is not to be given with the spoon, but the child is to suck it of a proper heat out of a tea-pot which is made for the purpose, and which has a piece of soft cloth tied over the perforated mouth. This diet may be occasionally alternated with a little weak veal or beef soup. Panado, made with crumb of bread, is not proper; and meat, made with unbaked flour is still worse. In the third month, we may, besides the milk and water, and light soup, give occasionally a little spoon-meat, such as panado made with the crust of fine bread, and a little salt, which is better than sugar, care being taken to break down the lumps completely. This to be mixed with milk. Sago, salup, calves feet jelly, &c. are also very proper; and as the child advances in life, eggs in the form of light custard, &c. are allowable. Some have proposed a panado made with the flour of wheat malt. By attention, a child may be taught to eat at pretty regular hours\*, especially after he is a few months old; and great care should be taken, that he do not eat too much at a time. If the child is not suckled, we as-

\* It is also of advantage, that when a child is brought up on the breast, he be not applied at all hours indiscriminately; and no child should be allowed to suck whilst the nurse is asleep, as he is apt to surfeit himself.

certain that the artificial diet is agreeing with him, if he be lively and easy, and the bowels are correct. But when it does not suit, as is too often the case, he is either dull and heavy, or cries much, and often the bowels are either bound or too loose; and in both states the stools are foetid, and have a bad appearance. If this condition of the bowels cannot be corrected by medicines, the child in all probability will be lost, if a nurse be not procured; convulsions, or diarrhœa will carry him off.

When a child is brought up on the breast, there is no occasion, if the supply be abundant, to give him any other nourishment for three or four months. After this time, however, it will be proper to give a little food of the kinds mentioned above, and the proportion ought to be gradually increased, as we proceed to the time of weaning, by which the organs of digestion are enabled to accommodate themselves better to the change of diet which then takes place. With regard to the age at which a child should be weaned, it is not possible to give any absolute rule. In general, the longer it is delayed the better does the child thrive, provided the milk be good. At all times, delicate, should be nursed longer than robust, children; and, if possible, weaning should not be made to interfere with the developement of teeth, nor be attempted in the prospect of, or soon after the cure of, any debilitating disease. If the mother's health permit, children may be suckled from nine to twelve months. After the child is weaned, the diet must be carefully attended to, and should consist of light soup, eggs, bread, and milk. In Ireland, potatoes form a principal part of the diet. In Scotland, oat-meal porridge is a common diet, and with many agrees very well; but it is, notwithstanding, apt to be heavy and binding, unless it have an admixture of barley-meal, which corrects it. As soon as teeth sufficient to masticate appear, a little animal food may be given once a-day.

The dress of children, as they grow up, must be regulated, in some respect, by the custom of the country, and the season of the year. It ought always to be easy and warm. Mr Locke advises, that a child should wear thin shoes, and get



wet feet, that he may become hardy ; but experience proves, that the children of the poor, who are exposed to many privations and hardships, are not improved thereby. Cleanliness is essential to health, and the whole surface should be washed once a-day at least, and the hair daily combed and brushed, which may prevent scald head. The exercise should be proportioned to the age. Infants sleep much, and can take no exercise, if we except that given by their nurses ; but when they are about two months old, they may be placed on the carpet, and encouraged to creep. When they are able to walk, they should be allowed to run about freely ; and it will be of great advantage, where circumstances permit, that the first years of life be spent in the country.

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## CHAP. II.

### *Of Congenite and Surgical Diseases.*

#### SECTION FIRST.

WHEN a child is born, it is necessary to ascertain that it have no congenite imperfection, or have met with no accident during birth. I can here only make a few short remarks on some of the most frequent and important imperfections. The first I shall notice, is the hare-lip, which may exist in different degrees, and be accompanied with a vacancy in the palate. Sometimes an operation has been performed soon after birth, but it often fails, and occasionally the child dies. It is better to delay it for ten or twelve months, or even longer. In the mean time, the child must be brought up on the spoon, unless the defect be so trifling, as to permit the child to suck a large nipple.

#### SECTION SECOND.

Imperforated anus may exist in different degrees. There may be an appearance of anus, but an obliteration a little higher up. This is discovered, by introducing a bit of oiled paper rolled up, which ought always to be done when

the child is long of voiding the meconium. If the paper be soiled with fæces, we may be sure that the rectum is pervious. A blunt probe, cautiously introduced, will also ascertain the state of the gut. Sometimes the anus is covered with a thin membrane only. In other cases, a great part of the rectum is wanting, or it terminates in the bladder of the male, or vagina of the female, which last is not a fatal deviation. It is proper always to make an incision at the anus, or at the spot where it ought to open, if there be no mark of it; and this is to be carried about half an inch or an inch deep. If no intestine be found, a trocar or lancet may be passed a little deeper in the proper course of the rectum. If, by any of these means, the bowel be opened, a tent should be employed, to keep the aperture from closing\*. But if it be not readily found, we are not to prosecute the dissection farther, but must form an artificial anus, by making an incision at the lower part of the left iliac region, sufficiently large to allow the colon to be brought out, opened, and the extremity retained to the wound†.

Imperforated urethra is chiefly met with in the male sex, and is to be remedied by an artificial opening in the proper direction, if the urethra seem to be pervious to a certain extent. But if it be altogether wanting, relief in the meantime must be obtained, by puncturing the bladder. Retention of urine, not dependent on malformation, is readily removed, by introducing a probe into the bladder. Deviations in the structure of the vagina and hymen have already been considered.

Imperforated meatus auditorius is very rare, and can seldom be remedied, except there be merely a membrane stretched across the canal. Adhesion of the eye-lid is often

\* In a case operated on by M. Cervenon, where the incision was obliged to be carried an inch high, it was necessary to use a bougie for a year. The child was enabled to retain the fæces, but the anus appeared as if it were sunk an inch deeper than usual. *Recueil Period. Tom. I. p. 36.*

† Vide Observations on this subject, by Dumas and Allan, in the *Recueil Period. Tom. III. p. 46 and 123*; and a case in point by Duret, in *Tom. IV. p. 45.*

complicated with a defect in the eye-ball itself; but when this is not the case, an operation will be adviseable.

#### SECTION THIRD.

Sometimes the umbilicus is peculiarly large, and hernia takes place soon after birth, but still more frequently betwixt the second and fourth month. Two modes of treatment may be adopted. The first is compression, carefully maintained, which should be always tried. This, in some instances, produces a radical cure; the umbilical opening contracting, which it never does in adults. The second mode is, reducing the intestine, and tying the sac with a single or double ligature. It has also been proposed, to open the sac, and close the umbilical aperture by pins or stitches; but this has no advantage over the double ligature. Sometimes, a very great portion of the intestines is found protruded at birth, into the sheath of the cord. This may be complicated with an imperfect or transparent state of part of the abdominal parietes; but whether it be or not, the child generally dies within forty-eight hours. The abdomen is too small to receive back the intestine quickly; and even although it could be reduced, the child, if we may judge from experience, has no great probability of existing. In one case, Mr Hey found the tumor burst during labour. Other species of hernia are to be treated on general principles. By the use of a bandage made with an easy spring, children, when they are some months old, may have hernia cured.

#### SECTION FOURTH.

Spina bifida is an imperfection of the vertebral canal and the spinal marrow. The bone is deficient generally about the lumbar vetebrae: a tumor is formed externally, which contains a fluid, and the skin is usually livid. The marrow stops at the commencement of the tumor, but sometimes begins again below it; or small nervous twigs arise from the inner surface of the sac, and, pass out to form the nerves of the inferior part of the body. This is a fatal dis-



case, and death is generally preceded by inflammation or gangrene of the tumor. In some instances, the sac is open at the time of birth.

The object, in this case, is to preserve the tumor entire as long as possible, for the child dies soon after it bursts. Astringent lotions are commonly employed. Ointments, containing preparations of lead, are also used.

#### SECTION FIFTH.

Marks and blemishes are very frequent, and may be placed on any part of the body. They are of two kinds: First, simple discoloured patches, generally of a red colour, and not elevated. These are not dangerous, but rarely admit of cure. Second, elevated discoloured marks, which are of a purple hue, and very vascular. These are apt to increase, and at last bursting, a fatal hemorrhage may take place. They may be seated on the face, or in the lip, eye-lid, &c. or on the spine, resembling spina bifida, but are more solid or spongy, and the bone is not deficient. These ought to be extirpated, as soon as they begin in the smallest degree to increase. Small marks have occasionally been removed by raising the skin with a blister, and then applying mild escharotics.

#### SECTION SIXTH.

Children may, especially after tedious labour, be born with a circumscribed swelling on the head. This seems to contain a fluid, and has so well defined hard edges, that one, who, for the first time saw a case of it, would suppose that the bone was deficient. It requires no particular treatment. By applying cloths dipped in brandy, the effused fluid is soon absorbed.

#### SECTION SEVENTH.

Distortions of the feet are not uncommon. They are called *vari*, when the foot is turned inwards; *valgi*, when outwards. These and similar deviations are to be cured by pressure, applied with proper bandages adapted to the

nature of the case. They must operate constantly, but gradually, and ought to be applied as early as possible.

#### SECTION EIGHTH.

When the frenum linguæ is too short, or attached far forward, the child can neither suck well, nor speak distinctly. It is very rare in its occurrence. I have not seen two children where it was really necessary to perform any operation; for in all the rest, the child sucked the finger, or a good nipple, very readily. The operation consists in dividing to a sufficient extent the frenum, with a pair of blunt pointed scissors. If the artery be imprudently cut, the hemorrhage is to be checked by compression or cautery.

#### SECTION NINTH.

Imperfection or malformation of the heart is a very frequent occurrence; or the foetal structure may continue long after birth. If the imperfection be great, the symptoms come on almost immediately after birth; but if slight, or consisting merely in a continuation of the foetal structure, they may not come on till the child begin to walk, or get teeth, or even later. The child is dark coloured, or the skin has a dirty appearance, the nails and lips are livid, the breathing is more or less difficult, and he is subject to attacks of asthma, or a kind of suffocating cough, like that in peripneumonia, or hooping cough; and whenever this attacks an infant, I augur very ill. I have no remedy to propose. Comparative ease may be obtained, by keeping the child as quiet as possible, avoiding a loaded stomach, or costive state of the bowels. For an account of the different kinds of malformation, I refer to my brother's Work on Diseases of the Heart.

#### SECTION TENTH.

Children have sometimes a swelling of the breasts after birth. This is chiefly owing to secretion of a milky fluid, and much injury is often done by attempting to squeeze it out. Gentle friction with warm oil is of service; but if in-

Inflammation come on from rude treatment, saturnine lotions must be employed.

Hydrocele generally goes off, by applying compresses dipt in solution of muriate of ammonia. A puncture is rarely necessary. Phymosis requires astringent lotions. Discharges of bloody or serous fluid from the vagina or urethra, are easily cured by ablution. Prolapsus ani is to be cured, by keeping the bowels open, using the cold bath, and returning the gut whenever it protrudes. Incontinence of urine, during the night, often depends on a bad habit, and is to be treated accordingly. When it continues long, the cold bath is proper..

Excoriation of the navel yields readily to cleanliness, and dressing with cerussa ointment; but if the constitution be bad, gangrene may take place. This is to be managed, by applying camphorated spirit of wine, supporting the strength, and keeping the bowels open with calomel. Hemorrhage from the navel, after the cord falls off, is to be checked by compression or caustic.

Scalds and burns are best cured, by applying instantly cloths wet with strong vinegar. This is the proper practice whatever part is injured; but when the face or neck are scalded or burned, it is of the utmost importance to prevent a mark, and nothing does so more effectually than the instant application of strong vinegar. This, if the injury be slight, prevents the part from blistering, or only a very slight vesication takes place. After a few hours the vinegar may be discontinued, and the part dusted frequently with cerussa, or we dress with cerussa-ointment, or anoint the spot with this, and then make it dry with cerussa or chalk. The part is to be washed at least once a day, to remove any irritating matter which might fret it.

If vesications have formed, they are to be opened with a very small puncture to let out the fluid, and then vinegar is to be applied; or if this give much pain, a thin cloth dipped in oil, may be interposed between the tender parts and the vinegar.

In more extensive and severe burns, oil of turpentine alone, or mixed with unguentum resinosum, forms the best dress-



ing for some time, and then the sore is to be covered with powdered chalk, which is to be continued till it heals. It represses fungus, and forms an artificial scab. In all cases, pain is to be allayed by opiates, and the bowels are to be kept open.

Ear-ache is a very frequent and painful disease of children. It is discovered, if the child be old enough, by his complaining of his ear; but if he is too young to do this, it may be suspected, by his being seized with a sudden and severe fit of crying, as if he had colic, and like it, the pain seems to remit occasionally. He does not, however, spur with his feet, nor is the belly hard, but he is restless with his head, and complains if his ear be touched. In some time he falls asleep, and next day perhaps his cap is stained with matter. Nothing gives so much relief as heat. Warm oil or a warm poultice is to be early applied, or the outside of the ear is to be rubbed with warm laudanum. If a fœtid discharge succeed this disease, and the child is deaf, the ear is to be daily washed out with milk and water by means of a syringe. Small blisters may be applied behind the ear, and the constitution is to be invigorated. The bowels in particular are to be kept regular. Many children have occasional discharges of matter from their ears, upon catching cold, without much pain, and at that time, they are deaf. But by keeping the ear warm, and by scrupulous attention to cleanliness, the discharge stops, and the hearing returns.

#### SECTION ELEVENTH.

The mucous secretion of the nostril is sometimes exceedingly fœtid, so that it is disagreeable to come near the child. The mucus dries, and comes away in thin pieces. Astringent injections, stimulating liniments, and a variety of local applications, as well as internal remedies, such as tonics, mercury, &c. have been tried. These have not always however, a good effect. At the age of puberty, the fœtor sometimes spontaneously ceases.

Fœtid discharge from the ears generally is accompanied with a destruction of the membrana tympani, and a caries of

the small bones. It is usually attended with deafness, and is very obstinate. Great attention is to be paid to cleanliness, and to the state of the constitution.

#### SECTION TWELFTH.

Infants are subject to inflammation of the eye, which is most frequently of the kind called purulent ophthalmia. This begins with redness of the eye-lids, which soon swell so much as to prevent their being opened. Then a copious and constant discharge of thick yellow matter takes place. This is found also spread over the eye. If the disease continue, ulceration of the eye, or a speck on the cornea, is produced, or the eye itself may burst. In bad cases, the eye-lids are also turned out, especially when the child cries. Both eyes are generally affected. This disease is cured sooner by astringent applications than by other treatment. A solution of sulphate of zinc in rose water, may be injected with a small syringe into the eye, two or three times a-day. Mr Ware recommends four ounces of sulphate of copper and of armenian bole, with an ounce of camphor, to be mixed. Of this an ounce is to be added to four pounds of boiling water, and allowed to settle. A dram of the solution is to be added to an ounce of water. When the eye-lids are turned out, he advises a poultice to be applied, made with equal parts of curd; formed by adding alum to milk, and lard or alder ointment. The bowels are to be kept open.

#### SECTION THIRTEENTH.

Children are subject to spongoid disease of the eye. The ball becomes slowly diseased, and its structure changed, so that all the parts are confounded, and the optic nerve becomes black or brown. The tumor bursts, and a fungus shoots out. The bones become carious, the disease spreads to the brain, and the patient dies, after much suffering. This has been improperly called cancer. It admits of no cure, except by very early extirpation. Every operation

that I have seen has been too long delayed, and the patients have all had a relapse.

#### SECTION FOURTEENTH.

Scrofula is dependent on a peculiarity of constitution, derived at conception. This is often marked by a very fine skin, light hair, large blue eyes, with dull sclerotica, and delicate complexion. Others have the skin darker, or of a rough dirty appearance, the hair is dark, the upper lip tumid, and the countenance sallow, and sometimes swelled. When the scrofulous constitution is not strongly marked, the person may pass through life without any inconvenience. But when it exists in force, different parts of the body are apt, without any evident cause, to have their action deranged; their structure is changed, and then inflammation slowly takes place. The glands are most frequently affected, but the joints or viscera may also suffer. I do not think it necessary to describe these changes, especially as I have elsewhere entered pretty fully into this subject. I shall merely state what ought to be done as a preventive, or as a cure. In the first view, we advise whatever can strengthen the system, and preserve the different parts vigorous and in health; such as the cold bath daily, gentle friction over the whole surface for half an hour every evening, regular exercise in the open air, great attention to cleanliness, an open state of the bowels, and good nourishing diet, with a small proportion of wine. Animal food is much recommended. Sea bathing is useful. When the glands are swelled, or other parts are enlarged, it is of service to rub them gently with oil for half an hour three times a-day, and apply, in the intervals, pledgits dipped in a solution of *cerussa acetata*. Hemlock poultices are also useful. Electricity or galvanism are sometimes of service. When the tumors tend to suppurate, that process should be assisted by poultices, blisters, and electricity. The abscess should be early opened, and then stimulants are proper. The constitution is to be treated in the way already mentioned. *Muriate of lime*, or of *barytes*, *cicuta*, bark, and great variety of medicines, have been ad-



vised, but I do not know that any one can be depended on. Medicines are chiefly useful to obviate existing symptoms, such as costiveness, &c.

Diseases of the joints and spine are to be managed chiefly by issues.

#### SECTION FIFTEENTH.

The disease called rickets is characterised by flabby muscles, relaxed skin, sallow or bloated countenance, debility, listlessness, and softening of the bones, so that the long bones become more or less curved, and their extremities enlarged. The ankles and wrists swell first, then the back changes its shape, and the breast protrudes. The bones of the pelvis approach more nearly together, the sacrum coming forward. The head is increased in size, and the belly likewise becomes large and hard. The appetite and digestion are impaired, the bowels are bound, or foetid stools are passed. The pulse is weak and frequent. The teeth are late of appearing, and are not good. The mind is often prematurely advanced. This disease may prove fatal, by ending in water of the head, convulsions, or hectic fever; but it often is cured spontaneously, or with assistance. It usually attacks betwixt the sixth month and second year, but it has been known to affect even the foetus in utero. It is to be treated by a course of laxatives, to bring the bowels into a proper state, the cold bath, regular exercise, nourishing diet of animal food, general friction over the body, chalybeate medicines, and warm clothing.

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### CHAP. III.

#### *Of Dentition.*

THE formation of the teeth is begun long before the foetus leaves the uterus. It is carried on slowly, and is not completed for several months after birth. The parts concerned in this process, are the jaw, the gum, and the soft rudiments of the tooth itself. The jaw, at first, has only a

channel running along its surface; but this afterwards is divided by transverse septa, into separate cells, which are the origins of the alveolar processes. In each of these is lodged a membranous bag, containing a soft pulp. The bags consist of two lamina, both of which, especially the outer one, are vascular. These sacs adhere firmly to the gum, so that if it be pulled away from the jaw, the sacs come with it; the pulp is also vascular, and assumes nearly the size and shape which the body of the tooth is to have when ossification has commenced. The tooth consists of two parts, bony matter, and cortex striatus, or crystallized enamel, covering the bone. The bone is formed on the pulp, which gradually ossifies; and in the eighth or ninth month of the fetal life, all the pulps have begun to ossify, and at birth the shell is considerably advanced. Soon after the process begins, the inner surface of the sac deposits a soft earthy substance, which crystalizes and forms enamel. When ossification is advanced so far as to form the shell of the body of the tooth, the lower part becomes contracted, so as to form the neck; and as the shell thickens, the pulp, though diminished in quantity, protrudes through the neck, forming a kind of stalk or mould for the fang. If the tooth is to have two fangs, then a septum is stretched across the cavity of the neck, and the pulp protrudes in two divisions. As ossification advances on the root, the body rises in the socket, and the sac rises with it; but in proportion as the enamel is crystallized, the sac becomes less vascular and thinner, and at last is absorbed; and when the tooth has acquired its proper height, the whole membrane is destroyed. Thus it appears, that the sac is not stretched, and bursts by distension, but is absorbed, and being fixed to the neck of the tooth, and not to the jaw, it rises with the tooth.

There are only twenty teeth evolved in infancy, ten in each jaw, and these are not permanent. They are shed, to give place to others more durable and more numerous, as the jaws are longer in the adult. The permanent teeth begin to be formed even before birth. Like the fang of the tooth, they are set off from the body of the temporary tooth.

A small process or sac is sent off backwards. This is lodged at the back part of the socket, where a little niche is first formed for its reception, and then a distinct socket. Hence the temporary and permanent teeth are connected together, and this connection remains for a considerable time. In the foetus, there are, besides the temporary teeth, the rudiments of the two first permanent grinders, therefore there are twelve sacs in each jaw. The sac of the anterior permanent grinder sends, when the jaw lengthens, a process backward, to form the next grinder; and it again, in course of time, sends off the third grinder.

Generally teeth cut the gum, about the sixth or eighth month after birth. The two middle incisors of the lower jaw first appear, and in about a month those of the upper jaw come through. Then the two lateral incisors of the lower jaw, and next those of the upper one, appear. About the twelfth or fourteenth month, the anterior grinders of the lower, and soon those of the upper jaw, cut the gum. Between the sixteenth and twentieth month, the cuspidati appear; and from that period to the thirtieth month, the posterior grinders come through; so that the child, when about two years and a half old, usually has all the first set of teeth. These continue till the sixth or seventh year; and as the permanent teeth are in progress all this time, we find, besides the twenty teeth which are visible, twenty-eight below the gums. At this time, the two first permanent grinders appear at the back part of the jaw, and the middle incisors of the lower jaw loosen and drop out; and by degrees, all the milk teeth give place to others which are larger, stronger, and better adapted to the increased size of the jaws. In this curious process, which strongly displays the wisdom of God, we are early taught the perishable nature of our frame. But it is also a pleasing reflection, that dissolution is succeeded by a state of greater perfection.

Many children cut their teeth with great ease and regularity, but some suffer considerably. It is usual for the child to have some irritation of the mouth during dentition. The gums are hot and itchy, and somewhat swelled or full over



the tooth, and the anterior edge is not sharp as formerly, but is rounded, and the investing membrane unfolded. The secretion of saliva is increased; and the stomach and bowels sometimes are rendered irritable. The symptoms seldom continue urgent above ten days at a time. If the child be very irritable, and the tooth advances fast, or several teeth come forward at the same time, very unpleasant effects may be produced, such as severe bowel complaints, or fever, or spasmodic cough, or convulsions; or the skin is affected, an eruption appearing on different parts, which is a much more trifling effect than any of the former. When the first grinders and cuspидiti are cutting, and come forward quickly, there is great danger, for there are then, as Mr Fox observes, eight teeth making pressure on the gums. In every case of troublesome dentition; we have three indications to attend to. *First*, to allay local irritation. *Second*, to alleviate urgent or symptomatic complaints. *Third*, to support the strength.

The *first* is accomplished most effectually, by dividing the gum with a lancet, completely down to the teeth, if it be considerably advanced. Even when it is not so far advanced, as to be near the surface, the division of the gum gives temporary relief. Gum-sticks act something in the same fugacious manner; by enabling the child to press, or rub the gum a little, he obtains a short relief. All children instinctively, thrust their fingers into the mouth, and this may be permitted; nor is there any risk of a bad habit being induced. This is as useful as the gum-stick, and safer; for a hard gum-stick is apt to be thrust into the eye, or the gum may be bruised by it. A crust of bread is often used, but part of it may break off, and choak the child.

*Second*; We allay general irritation, or fretfulness, by keeping the bowels open, and exposing the child freely to cool air. The cold bath is also useful every morning, and at night, the child if hot, may be sponged with cold water. If this do not prove effectual, we may rub the spine and belly with laudanum, which acts as an opiate without inducing the injurious effect on the stomach, which the internal exhibi-

tion too often causes. Fever if high, is to be abated by the use of the tepid bath morning and evening; the bowels are to be kept open, and if the child be plethoric and drowsy, besides giving a smart purge, either one or two leeches ought to be applied to the fore-head; and if the determination to the head continue, the scalp should be shaved, and a small blister laid upon it. Diarrhœa, if considerable and detrimental, is to be abated by those means, which will hereafter be pointed out; and especially, if it be severe, by opiate clysters; at the same time, that we, if the stools are very bad, give small doses of calomel at proper intervals, to bring the bowels into a better state. The greatest number of children who die during dentition, perish in consequence of obstinate or neglected diarrhœa. Sickness, loathing at food, and ill smelled breath, require a gentle emetic. Spasmodic and convulsive affections require the warm bath, antispasmodics, and the general treatment which will hereafter be pointed out. It is not easy to describe the different symptoms which occur during dentition, or may be connected with it; but one general rule must be laid down, namely to treat them, as we would do in any other circumstance, with the additional practice of cutting the gum. Delicate and slender children suffer chiefly from bowel complaints, and spasmodic affections; stout or plethoric children, are more apt to suffer from acute fever, with determination to the head.

*Third,* We support the strength directly by the breast milk, arrow root, beef tea, or, if necessary, by clysters of veal soup, or calves feet jelly; and indirectly by restraining immoderate evacuations. If the child have been recently weaned, it is often of service to apply him again to the breast.

## CHAP. VI.

*Of Cutaneous Disease.*

IN the following short account of cutaneous diseases, I may perhaps have committed some errors respecting the names of eruptions. Nosological writers, unfortunately, do not agree in giving uniformly the same name to the same disease; and perhaps it is not always easy to give a perfect definition by words alone. I have, however, endeavoured to detail faithfully, so far as I am able, the symptoms characterising the eruptions which I describe, by whatever name they may be called, and also to point out the mode of treatment commonly employed.

## SECTION FIRST.

The first eruption which I shall mention, is well known under the name of red gum, and is described very accurately by Dr Willan, as his first variety of strophulus, a papulous eruption. The strophulus intertrinctus, or red gum, consists of a number of acuminate elevations of the cuticle, of a vivid red colour, not in general confluent, and sometimes even pretty distant from each other. The papulæ are surrounded with a red base. This redness is often the most evident part of the eruption in very young infants, and the disease much resembles measles. It covers a great of the trunk, and keeps almost entirely off the face. In the centre of the spot, we may observe a very minute elevation or papula, with a clear top. There is no fever, nor has the child catarrhal symptoms. The eruption comes out irregularly, and is either more durable, more fugacious, or more partial, than the measles. On the feet, the papulæ are still more distinct. The papulæ of strophulus are often intermixed with small red specks, not elevated above the surface. They are hard, and contain no fluid, or only a very small quantity under the cuticle at the apex, giving it a glistening appearance; but they seldom discharge any fluid, and scarcely ever form pus. This eruption appears generally on the face and



superior extremities, but sometimes it spreads universally over the body. On the back part of the hand, the papulæ occasionally contain a little yellow serum, but this is presently absorbed, and the cuticle is thrown off like a slight scurf. This variety of strophulus generally appears during the first ten weeks\* of life, and is not productive of any inconvenience. It seems to be connected with the state of the stomach and bowels; and any uneasiness the child may suffer during the continuance of the eruption, or previous to its appearance, seems referable to this source. The particular connection existing betwixt the chylopoetic viscera, and the surface, I do not pretend here to explain or investigate. I hold the fact to be established, and from no circumstances more decidedly than these, viz. that in adults, certain kinds of food do, with individuals, invariably produce an eruption on the surface; and that in children, where all the system is much more irritable, trifling irritation of the bowels is followed by cuticular eruptions, whilst the sudden disappearance of the eruption, on the other hand, is succeeded generally by sickness and visceral disorder. I am inclined to attribute to a cause within the abdomen, all those eruptions which are not produced by the direct application of irritations to the surface. † The affection at present under consideration requires no particular remedies. It is sufficient to avoid the application of cold, which might suddenly repel the eruption; and filth, or other irritation, which might increase it, or superinduce another affection. Should the stomach or bowels be affected, or the child be oppressed, a very gentle laxative may be occasionally administered; or, should the bowels be too open, and the child flabby, a little tincture of myrrh, or myrrh with lime water, may be given, and, if necessary, an opiate. If the eruption be repelled, and the child thereafter be disordered, the warm bath, with a gentle laxative, will be proper.

\* Sometimes a few spots of this kind may be observed on the forehead of children at the time of birth.

† Dr Underwood is inclined to think, that when children are subject to repeated eruptions, the milk does not agree with the stomach, and ought to be changed. I am very much disposed to adopt his opinion.—See also Turner on Diseases of the Skin, p. 69.

## SECTION SECOND.

The next variety is the *strophulus albidus*, which is an eruption consisting of minute whitish specks, hard, and a little elevated; sometimes, but not always, surrounded by a very slight and narrow border of redness. No fluid is contained in the papulæ, which appear chiefly on the face, neck, and breast. This generally is met with after the period at which children are subject to red gum; it remains rather longer, but requires no peculiarity of treatment. Sometimes children, at a more advanced period, have this kind of eruption on the neck, which is exposed to the sun in warm weather. It has sometimes been mistaken for the itch.

## SECTION THIRD.

The *strophulus confertus* is a very frequent affection during dentition, but seldom appears before that period, though it may continue after it. It consists of papulæ, often set extremely close together, forming patches, varying from the size of a sixpence to a dollar. Such, at least, is the appearance on the face and arms, to which part it is often confined, especially to the former. But it sometimes appears on the trunk, and there the papulæ are larger, flatter, and surrounded with more inflammation, than those on the face or arms, looked at a distance like measles. This eruption not only varies a little, according as it appears on the trunk or extremities, but also according to the age of the child. For after the seventh month, we find, especially on the arms, the papulæ pretty large; and either red, with scarcely any appearance of lymph at the top, or of a light yellow colour, but the base surrounded with a halo or inflamed rim. These papulæ may on some parts be distinct from each other, whilst elsewhere they form clusters so close, that the redness surrounding one communicates with that of another, forming altogether a large inflamed ground-work. In some cases, the red patch is the prominent feature; it may be as large as a dollar, with innumerable little dots within it, like

pin heads, with clear or watery-looking tops, or larger red hard papulæ. This eruption is sometimes preceded by sickness, and, in certain circumstances, has been mistaken for measles; but it is attended with little or no fever, and has none of the catarrhal symptoms met with in measles. By not attending to the characters of the two diseases, they may be confounded; and not unfrequently, when young children take measles, the *strophulus confertus* appears on the arms, previous to the proper eruption, or even along with it. Dr Underwood says this eruption does not dry off the measles; but as Dr Willan remarks, it often does terminate with a slight exfoliation of the cuticle. A variety of this disease appears like red patches in different parts of the body, particularly on the arm, and often coming out in succession. They are as large as a split pea, and a very little raised toward the centre. By near examination, several small papulæ may be discovered, which are something like vesicular points. In three or four days, the patches become yellowish or brown, and covered with small scurf. This is denominated by Dr Willan, *strophulus volaticus*, and is said not to be very common, but I think it is frequently met with. It is seldom necessary to give any medicine for this complaint. If, however, it be troublesome, it is usual to prescribe gentle laxatives, and testaceous powders. Some advise emetics, and the use of the bark; but neither, I believe, are in general necessary.

#### SECTION FOURTH.

*Strophulus candidus* consists of papulæ having a smooth shining surface, which appears of a paler colour than the rest of the skin, and the base is not surrounded by any inflammation. It is described by Dr Underwood as resembling itch, but it is neither red nor itchy. It generally either attends dentition, or succeeds some acute disease of children, and is justly considered as a very favourable symptom. It is most frequently met with on the trunk of the body, the arms, or forehead. In a few days the papulæ die away. No particular treatment is necessary.



## SECTION FIFTH.

A different eruption from any of the foregoing is the lichen, a term restricted by Dr Willan, in his elaborate work, to a papulous eruption, chiefly affecting adults. It may, however, appear also in children; and I have seen it succeed some of their febrile diseases, as, for instance, measles. It consists of numerous distinct papulæ, some of which are pale at the top, but very slightly red at the base; these are generally small like pin heads. Others are larger and flatter, and more inflamed, but have always at first a clear apex, and do not end in ulceration, but die away in slight scurf. Sometimes on the body, there are small shining or silvery looking patches, from exfoliation of the cuticle; or the skin may peel off more extensively, as if it had been blistered. They resemble often the papulæ in strophulus, but seldom form in clusters, and have not, in general, any diffused redness connecting one papula to another. There is, however, sometimes about the joints or fore-arm, a considerable degree of red efflorescence, covered with scurf. This eruption may be produced by exposure to heat, and by drinking cold water when heated, or other less obvious causes. It is frequent in warm weather, and a species of this is known under the name of prickly heat. It is preceded often by febrile symptoms, and the eruption itself may last for more than a fortnight, but in a few cases it goes off in a day or two. These papulæ, at different stages, bear a resemblance to two very dissimilar diseases, the itch and the measles; but it is not pustular like the itch, neither does it ulcerate; it is not very itchy, and if scratched so as to take off the top, it does not yield matter, but a little bloody scab is formed. It differs from the measles in being papulous, and having on the spots, before they form slight scurf, a clear looking top; it in general lasts longer than the measles, and is not attended with catarrh. Farther, it is sometimes accompanied with a broad scurfy efflorescence, about the elbow joint, or other flexures. A suitable dose of calomel is the best remedy, or, should the patient be oppressed, an eme-

tic and saline mixture may be given. When there is no febrile affection, it will be sufficient to keep the surface clean by means of the tepid bath.

#### SECTION SIXTH.

Intertrigo is a kind of erythematic affection of those parts of the body where the skin forms folds or sinuosities, as, for instance, the joints of fat children. It also is very common about the nates and inside of the thighs, in consequence of the urine fretting these parts. The inflamed surface ought to be washed occasionally with tepid milk and water, and the child should never be allowed to remain wet, but ought to be bathed, and gently dried after making water, when the thighs are affected. Afterward the parts are to be dusted with some cool powder, such as tutty, white lead, levigated flowers of zinc, &c. It is not usual for intertrigo, to end in gangrene or suppuration, but sometimes the form of the disease changes, and the cellular substance inflames; either of these terminations may take place, and will require the usual treatment.

#### SECTION SEVENTH.

Crusta lactea, or milk blotch, is a scabby eruption, which appears generally first on the cheeks or forehead, and then extends over a considerable part of the face, and even the scalp. This disease belongs to the *achores*, or pustules containing a fluid something like honey. The pustules are red, and the top soon becomes covered with a laminated scab. Sometimes the pustules are large and distinct, but often small and confluent, so as to form a considerable patch\*. A succession of pustules may appear on the same place. They are not in general painful, but are occasionally itchy, especially at night. In some cases, the eruption spreads to the neck, breast, arms, and legs. During dentition, especially if the child be plethoric, this eruption is frequently met with on the face, while the body is covered with *papulæ*, like *prurigo* or small *achores*. Inflamed pustules first form on the face, con-

\* "*Incipit a vesiculis numerosis cohaerentibus, oleoso succo turgidis.*" Plenck 71.

taining a yellow viscid fluid, and having red margins, then they grow larger, and thick elevated crusts form, of a yellow or brown colour. When the crust is rubbed off by the child, the part is dark coloured, and watery-looking, with little bits of crust adhering to it. This disease leaves red blanes for a time. The skin about the neck has sometimes a scurfy herpetic appearance. Strack remarks, that in *crusta lactea*, the urine has a particular smell, like that of a cat. Lory describes a variety of this disease, under the name of *ignis sylvestris* or *volaticus*; and says it goes off in blisters or thin crusts, without any inconvenience, except a degree of itching. He remarks, that it may attend the cutting of every tooth, and may even continue for years, but this circumstance I have not met with. He has observed, that when the glands of the neck swell, the eruption goes off, and when they subside the eruption returns. This is a disorder which is often met with when the child is on the breast. It has been attributed to the richness of the milk, and generally goes off after one or two teeth have made their appearance\*. It is not attended with any danger, scarcely with inconvenience, and never leaves any mark or scar behind it. But having been sometimes, at an early stage, mistaken for syphilitic blotches, it has caused much unnecessary alarm. With respect to the treatment, very little is necessary, except keeping the bowels open, or giving purges occasionally; and if the child be plethoric, making the diet more sparing. In general, strong local applications are improper; but if any particular part is very sore, a little weak solution of acetate of lead may be safely applied for a short time. In obstinate cases, sulphur-vivum-ointment has been found serviceable. Lime water is also proper, or weak solution of muriate of ammonia, or ung. hyd. nit. Dr Armstrong advises the *lac sulphuris*, in such doses as keep the bowels open, and Dr Underwood recommends Harrowgate water; both of which will be found of benefit. Stoll proposes, after Strack, a decoction of the *viola tricolor* in milk, to be taken internally. Frank observes, *externis hac*

\* Some have considered this as a scrophulous disease. Vide Stoll *Preleç. t'io res.*—Frank de Morl. Curand, &c.



*in tinea remediis vix locus est, quæ illam exsiccant, cum damno admoventur.*

#### SECTION EIGHTH.

During dentition, or in consequence of affections of the bowels, different anomolous eruptions may appear, which are not distinctly referable to any well defined species. Sometimes we find upon the arm, one, two, or three inflamed portions of the skin, something like small-pox, but rather larger, with a small acuminate speck of lymph beneath the cuticle at the apex, or sometimes the top is flattened and shrivelled. Occasionally, a greater number of pustules appear on the body, pretty large, hard and inflamed round the base, with a white top. This kind of eruption is not attended with fever, and is neither painful nor itchy; it goes off in a few days without any medicine.

In general, it should be a rule in the treatment of eruptions, to wash the surface, once a-day at least, with tepid water and keep the bowels open. In obstinate cases, preparations of sulphur, antimony, calomel, and arsenic, have been employed; but the last is too dangerous to be admitted into practice. Sometimes the juice of the sium aquaticum, in considerable doses, or the decoction of the woods, will be of service; and in indolent eruptions, the tincture of cantharides has been beneficial. As external applications, lemon juice, the decoction of hellebore, or of stavesacre, infusion of tobacco, as a partial lotion to the part, sulphureous baths and lotions\*, sulphur ointment, ung. acid. nitros. ointment of nitrated mercury, or weak solution of corrosive sublimate, or of acetate of lead, or camphorated liniment, or the application of cloths wet with butter milk, are employed, sometimes with benefit. Sea-bathing is frequently of service and a bath of warm sea-water often does great good.

#### SECTION NINTH.

Authors describe some other eruptive diseases, which may

\* Diluted hepatised ar. mercuria, but especially solutions of the sulphuret of lime or pot-ash, may be employed for this purpose.

be noticed here with propriety: one of these, called pompholyx, consists of a number of vesications of different sizes, appearing on the belly, ribs, and thighs, and containing a sharp lymph; they may appear during teething, or in bowel complaints, and continue for several days. These vesications are not uncommon in very warm weather; and I think boys are most subject to them, especially about the ankles if they do not wear stockings. Lory considers this disease as a kind of erysipelatous affection, produced by the heat of the sun. It requires no medicine, but the lymph ought to be let out by a small puncture.

A similar appearance, generally attended with fever, and sometimes with aphthæ, is more serious, and is called pemphigus infantilis. The vesicles, at first small, soon become pretty large and oval, and their contents become turgid. They appear soon after birth, generally in emaciated infants, affect both the trunk and extremities, are surrounded with a livid inflamed halo, and when broken, are succeeded by spreading ulceration. Notwithstanding bark and cordials, the fever and irritation generally prove fatal in about a week; and only those children are saved, who were previously possessed of a tolerable degree of strength. This may be mistaken for syphilis.

Another kind of eruption attacks children above two years of age, suddenly covering the greater part of the body. It consists of red elevated spots, at first sight, something like a kind of pock. The spots are distinct and most numerous on the thighs and legs. They are of a dark red colour, pretty flat, with a smooth flatted vesicular top, which is dry, and does not burst, nor discharge matter, but gradually dries and desquamates. The eruption is scarcely painful or itchy, and is not attended with fever. It may continue for four or five weeks, and is sometimes combined with lichen, or other cutaneous diseases. The bowels should be kept open, and some advise antimonial wine to be given, with a little tincture of cantharides.

## SECTION TENTH.

Sennertus describes, under the name of sudamina, an eruption like millet seed, fretting the skin, and affecting children about the neck, arms, &c. Plenk defines it in the following terms. *Sunt vesiculæ granis milii magnitudine et similis, subito absque febre erumpentes.* The child should be bathed occasionally in tepid water. This eruption often takes place in hot weather. A similar eruption, attended with fever is also met with, which I find very well described by Dr Willan, in his reports on the diseases of London, under the name of acute miliaris. It does not affect infants, but children old enough to take active amusement. It begins with a febrile attack, attended with head-ach and pain in the back. The tongue is of a dark red colour at the edges, with the papillæ prominent as in scarlatina; the rest of the tongue is covered with white fur. The pulse is small and frequent. Presently the patient complains of heat and pricking at the surface, is sick at stomach, and perspires freely through the night. At a period varying from the third to the sixth day of the fever, an eruption appears, of small pustules like millet seeds. These are of a red colour, but contain at the top a white lymph, and are either diffused over the body, or collected in patches on different parts, especially the back and breast; they may alternately appear and disappear, and though the same pustule does not continue long, it may be speedily replaced. They may sometimes be combined with small red efflorescences, and generally vesicles appear on the tongue and fauces, ending in aphthous ulceration. The complaint often terminates in about ten days, but it may be prolonged even to twenty. It is frequently the consequence of being overheated, or drinking cold water in that state. It requires first of all an emetic, and then a purgative. During the course of the disease, the patient should be kept moderately cool, and use acidulated drinks freely.



## SECTION ELEVENTH.

Itchy eruptions are frequently met with on children, but these are not always the true itch, nor the consequence of infection. The prurigo mitis, described and delineated very accurately by Dr Willan, is a disease often met with in spring. It appears without any previous indisposition, and consists of soft smooth elevations of the skin, or papulæ, differing in colour very little from the surrounding integuments. When they do become red, it is in consequence of friction. If the top be rubbed off, a clear lymph oozes out, which forms a thin scab, of a dark or almost black colour. The eruption is itchy, especially on going to bed, and if scratched, it may become pustular and contagious, which it is not in its early stage. At first, it may be removed, by washing frequently with tepid water and a little soap, or lemon juice; but if neglected, it requires the application of sulphur.

A variety of this disease consists of minute red accumulated papulæ, with a very small vesicle at the top, terminating not in suppuration, but yielding, when scratched, only a little clear serum. Sulphureous preparations give relief, and time, with attention to cleanliness, confirms the cure. Sometimes very little itching attends this eruption, and it disappears by using the tepid bath.

## SECTION TWELFTH.

The scabies\*, or true itch, is contagious, and consists of small pustules, which have a hard hot base, with a watery-looking top. They are attended with an intolerable desire to scratch; in consequence of which, the tops are rubbed off the pustules, and scabs come to be formed, partly by blood, and partly by a kind of matter, furnished by the little ulcers. But if the pustules be not disturbed, but removed by proper applications, they end in a slight desquamation of the cuticle, "*quæ vix furfur aliquod ostendat.*" The itch first ap-

\* Children, in consequence of handling mangy dogs or kittens, are sometimes affected with an obstinate itchy eruption, which is not scabies, but may be cured by the remedies used for the itch.

pears betwixt the fingers, on the wrists and hams, but if neglected, it may spread over the whole trunk and extremities, and, in consequence of the continual irritation, impairs the health; nay, some children die in consequence of it. In neglected cases, the inflammation surrounding one pustule spreads to another, and the part becomes universally red, with pustules or scabs, according to circumstances, scattered over it. This is often the case on the back of the hand, and forepart of the feet. Sometimes small boils and phymata appear in the course of the disease, on the thighs or body, or about the face. The cure may generally be accomplished, by frequent ablution, and rubbing the parts affected with sulphur-vivum ointment \*, which, in obstinate cases, may be rendered more effectual by the addition of powdered hellebore, or sal-ammoniac. Rosenstein says, that the hands are very soon cleared, by washing them with a strong decoction of juniper berries; and that when the eruption is great, as, for instance, on the feet, he has applied cabbage leaves with advantage. They cause at first a great discharge, but the parts heal afterwards.

Sometimes the friction excites an eruption different from iteh, and kept up by the remedies intended to cure it. M. Burdin remarks respecting this, that it consists of small round pustules, “ qui se remplissent quelquefois de sérosité, et dont “ la cicatrice laisse le plus souvent une tache d’un rouge brun, “ le prurit qu’elle occasione est aussi moins fort que celui de “ la gale.” In inveterate cases, the use of Harrowgate water is of great benefit. In order to avoid the smell of sulphur, other applications † have been employed, such as sulphuric acid, or nitrous acid combined with hog’s lard, ointment of nitrated mercury, camphorated ointment, hellebore, or corrosive sublimate, mixed with hog’s lard, &c. These often fail, and even when they do remove the eruption, the

\* Dr Joseph Clarke considers it as dangerous to use sulphur ointment with infants, lest the eruption be suddenly repelled; and advises rather to boil a piece of stick brimstone in water, in order to make a bath.

† M. Becu advises the following lotion: Take of tobacco leaves two pounds, sal ammoniac one ounce, ammonia two ounces, water three Paris pints. Infuse for two hours.



cure is said frequently not to be permanent. Itch may be combined with other diseases, such as herpes, syphilis, &c. in which cases, it is more obstinate than usual, and may sometimes require the use of mercury.

#### SECTION THIRTEENTH.

Herpes has been divided into different species. It has been described under a variety of names, and sometimes confounded with lichen; or its different appearances described under the name of impetigo. Strictly speaking, the eruption in herpes is vesicular, the base surrounded with erysipelatous redness, the top terminating in a thin scab or scale, and the vesicles in general small and confluent, and disposed to spread. But some diseases which consist rather of small pustules than vesicles, and others which have neither vesicle nor pustule, have been admitted as species of herpes. Plenck and others have described a great number of species; but we may be satisfied with enumerating the following, though, in strict nosology, they are not all referable to the same genus. 1st, The herpes farinosus, dartres farineuses, or dry tetter. This consists of efflorescent patches of various sizes, covered with scurf or small scales. The patches appear like flat red and slightly elevated portions of the skin, having a distant resemblance to the blanes of the small-pox about the twentieth day of the eruption, but darker in colour, and very soon covered with scurf, through the interstices of which the surface is seen to be red. The shape is irregular, and the size generally varies from that of a small split pea to that of a shilling. These spots usually begin like small pimples, slightly raised, with a very small vesicle at the top. They gradually extend into flat dark red spots, covered with slight scurf. Often they extend like a ring, or increasing circle which is red and scurfy, or vesicular, whilst the centre becomes sound. Sometimes there are many small vesicles near each other, which contribute to the formation of these patches. They are not painful, but itchy. The patches may be very few, or may be numerous, coming out on great part of the surface, but especially on the extremities and face; some-



times on the trunk, and about the arms. They frequently occur on the scalp, which becomes bald at the part, and the baldness increases, as the red circle extends. Within the circle the skin is whitish and a little scurfy. They are also to be met with on the soles of the feet. When the scurf falls off, the skin below, as Pinel observes, is generally sound, but continues discoloured for a length of time; and often the scurf is renewed, or new patches come out in other places. Sometimes, however, the parts become excoriated, and even fissures may take place, or the cuticular lines become more distinct, without excoriation. In consequence of excoriation, or from scratching, a fluid exudes, which forms rough irregular scabs of a yellowish colour, scattered over a pretty extensive portion of red skin, which is dry, but not smooth. Sometimes in the vicinity of this, we may observe a thick cluster, apparently of white papulæ, giving the skin a dirty white rough appearance. These, however, are vesicles, containing a very limpid fluid. Their base is white and hard. In young children, the nostrils are apt to become obstructed; and when the upper part of the face is much affected, the eye-brows and eye-lashes fall off. It requires considerable attention, in many cases, to distinguish this disease from syphilis. In some instances, especially in spring and summer, a variety of this is met with, the characteristic of which is, that the spots are smaller, and come out suddenly, and are occasionally preceded by slight fever. They are of a red colour, inclined to yellow, have little scurf, and continue for some time after the scurf falls off. This is sometimes combined with intertrigo and strophulus. Another form, met with frequently in adults, but seldom in children, is an universal affection of the extremities, and sometimes of the trunk also; the skin being covered with small scales, or scurfs, which are found in considerable quantity in the bed in the morning.

2d. *Herpes miliaris* \*, or wild-fire, which, when it appears

\* Some have ranked under this the *phyma* and *ecthyma*, but these are inflamed pustules. Others, with more propriety, have included the *eczema*, or eruption of small vesicles, with the inflammation, produced in summer by

on the lips, has been called *exanthema* or *herpes labialis*. This consists of minute pimples, or vesicles like millet seeds, which are confluent, appearing in clusters, or sometimes like rings. They contain a lymph of a glutinous nature, which exudes, and forms rough yellow scabs; and from the quantity of the fluid, the linen is very apt to stick to the part. When the scab falls\* off, it is apt to be renewed, or still more frequently the disorder spreads in a kind of circling direction. These rings or clusters may become very numerous, and sometimes invade pretty quickly; so that Lory is disposed to rank this among acute diseases. The parts are very generally very itchy. This disease is not always confined to the surface, but may also attack the throat. In this case, the local symptoms are preceded by fever for a day or two, and then vesicles appear on the fauces, which are soon followed by a herpetic eruption about the mouth, and inside of the lips. The internal affection ends in slight ulceration, the external in the formation of scabs, and the complaint is removed in about a week. If not known, it is mistaken for a more malignant disease. Dr Willan has described this under the name of *angina herpetica*.

Another species of herpes appears on different parts of the body, but especially on the face. It consists of a pretty large portion of inflamed skin, covered with different broad thin scales, which, when removed, are soon replaced. This is described as being a variety of *ignis sacer*. It is not so common with children, as in women, and it is very obstinate.

3d. The phagedenic herpes, or *herpes exedens*, differs from the former species, in ulcerating and destroying the skin, sometimes spreading along the surface, sometimes penetrating deep. It generally begins with small painful pustules, or *phlyctænæ*, with dark erysipelatous margins, which

the rays of the sun. The larger vesicle, called *pompholyx*, is different. In these eruptions, a liniment composed of sweet almonds and hog's lard, has been found useful. Sometimes heat, or other causes, produce a different kind of eruption, already described under the name of *lichen*.

\* If the scab be forcibly picked off, the part below is found raw and glossy, without apparent granulation.

discharge sharp matter, run together, are hot and itchy, and seem to eat away the skin, forming an ulcer called noma.

When the herpes farinosus is confined to a small part of the body, it will in general be sufficient to apply frequently to the spot, a little of the ung. hyd. nit. or ung. acid nitros\*. Should the spots resist this application, it may be useful to touch them with a weak solution of nitrated silver, or a strong solution of muriate of mercury, or lime water, and afterwards apply the ointment. If the herpes be extensive and obstinate, internal remedies are sometimes necessary, such as decoction of sarsaparilla, with a little antimonial wine; or Stoll advises cow's milk whey, with the juice of nasturtium. In all such cases, the daily use of the warm bath, succeeded by gentle friction with a dry cloth, will be highly proper. In obstinate cases, sulphureous baths are beneficial. In sudden eruption of herpetic spots, if attended with any slight degree of fever or sickness, an emetic, followed by gentle doses of calomel, will be of service.

The herpes miliaris, like the former, is often cured by the ointment of nitrated mercury, or by being bathed with water containing a small quantity of nitrous acid. When extensive and obstinate, sudorific decoctions may be required and stimulating or astringent local applications, such as ointment of red nitrated mercury, lime-water containing muriate of mercury, or solutions of the sulphate of zinc, or acetate of lead. Sometimes it is necessary, by fomentations or poultices, to loosen and remove the scabs, previous to making these applications. Calomel is useful.

The spreading herpetic ulcer generally requires strong stimulants, such as caustic, butter of antimony, camphorated spirit of wine, resinous ointment, of terebinthinae, &c. If, however, the ulceration be very superficial, an ointment, containing white calx of lead, or calx of zinc, is often of service; and sometimes the spreading may be stopped by cauterizing a narrow rim of skin round the ulcer. The in-

\* Frank recommends the tobacco cerate, for which he gives the following receipt: R. succi nicotianæ, ceræ flavæ, a ʒiii; resinæ pini, ʒiiss; terebinth. ʒss; ol. myrrhæ, q. s. fiat ceratum. De Morb. Cur. Tom. IV. p. 154.—With children this must be used cautiously.



ternal use of nitrous acid may likewise, in this kind of herpes, be made trial of.

#### SECTION FOURTEENTH.

Children are sometimes affected with ichthiosis, a disease in which the skin becomes dry, and covered with scales resembling in their distribution, and sometimes in their appearance, those of a fish. This disease may come on at any period of life; it may even be connate, but this is very rare. It is proper to employ the warm bath, and during its use, to pick off the scales. Their regeneration is to be prevented by friction, and repeated bathing. Sometimes children have this disease conjoined with boils.

#### SECTION FIFTEENTH.

The scaly tetter, dry itch, or psoriasis of Dr Willan, consists of red rough spots, which are very soon covered with a laminated scale, sometimes as thick as paper, but generally thin, and very like a bit of the scale of a herring dried. They are irregular in their shape and size, occasionally not larger than a coriander seed; sometimes as large as the nail of the little finger, resembling a dried fish scale pasted on the skin; and frequently they are interspersed with shining silvery looking portions of the surface. These scales are formed by the exudation of a whitish matter, which is very glutinous, and, as Sylvius observes, stiffens the linen; when it happens to exude in sufficient quantity. The spots on children generally begin like papulæ, of small size, and vesicular at the top. These end sometimes in scurf, oftener in thin scales as has been described. On the back of the hand; the vesicles are sometimes pretty large; whilst in the palm of the hand, the eruption is rather pustular, and ends in broad thin rough seals of a yellow colour. In the early stage, it is sometimes combined with strophulus. The parts are itchy; but when they are scratched, matter does not come out by the removal of the scales, but a little blood flows. This eruption often begins on the face or neck, and spreads to the body and extremities. It is very obstinate, and some-

times destroys the nails. When it has continued for some time, the skin, especially about the hands and feet, is found to be universally red, with dark-coloured scales interspersed. The skin looks as if it had been scalded, and partly covered with thin scabs or scales, in different degrees of adhesion; and in some cases, the whole of the extremities, and even the body itself, or the head, becomes red, partially excoriated, and covered partly with scales and scurf, and partly with scabs, which are yellow, and pretty thickly set, often loose and easily detached. Sometimes on different parts of the body, particularly on the arms or legs, there are many soft red indolent bumps, more especially if the child have been seized with this disease soon after the small-pox or chicken-pox. The appearance on the head is nearly the same as in pityriasis, but it in general wants the white scurf. It is rare not to find the head affected in this disease.

Excoriation sometimes also takes place about the anus, with a slightly elevated state of the surface; in consequence of which, and the disease of the skin taking place soon after birth, I have been consulted respecting children given out to nurse, who were apprehended to have syphilis. Dr Willan remarks the syphilitic appearance of this disease, but justly observes, that all other marks are absent. The syphilitic form of this disease is attended with hoarseness, and the patches are of a livid colour, with a slighter degree of scaliness, and the margin is sometimes higher than the centre.

It is not, like the itch, very contagious, nor is it easy to say what occasions it; but we know, that inattention to cleanliness is favourable to its production. The application of preparations of sulphur, and ointment of nitrated mercury, with the use of the tepid bath, especially made with sea-water, daily, will often cure this disease; but in obstinate cases, we must give some sudorific, such as antimonials, or decoction of sarsaparilla, alone or with calomel, or have recourse to the Harrowgate or Moffat waters, which have great efficacy. They should be used both externally and internally. Solutions of soap, or of alkali, or of sulphuret of potash, form very useful baths. Decoctions of hellibore, or solution of muriate of ammonia or of oxy-mu-

riate of mercury are also proper as external applications. The application of cloths wet with butter-milk, or a poultice of butter-milk, and oat-meal, sometimes facilitates the cure.

#### SECTION SIXTEENTH.

Impetigo is a term differently applied by writers, and hence uncertain in its meaning. By this term, I understand a disease, which consists of broad vesicles about the size of a split pea, circular in general, but with a shelving jagged margin. These are surrounded with diffused redness, and contain purulent looking matter. Sometimes the top is dark coloured, as if it were filled with bloody lymph, and the margins are of a livid red colour. Some are of an irregular shape; and the contained fluid being very small, the general appearance of the whole blotch, is livid. These vesicles are very numerous, especially on the extremities, and soon form crusts, or thin flat rough scabs, of a yellow colour, inclining sometimes to brown or red. The scab is surrounded by a diffused redness, of irregular shape; and this red portion of skin seems a little radiated or puckered, as if drawn toward the scab. This disease is attended with itchininess, and, if much scratched, the parts may be fretted and ulcerate. It is occasionally attended with a rough-sealy appearance of the palm of the hand. Sulphureous preparations are useful, or the parts may be frequently bathed with solution of oxy-muriate of mercury, or the ung. hyd. nit. may be applied. The tepid bath should be used to promote cleanliness.

#### SECTION SEVENTEENTH.

The pityriasis is a disease known commonly under the name of the dandriff. It consists of a dry, scurvy, and sealy eruption on the head, amongst the hairs. Near the forehead, the skin is covered with thick white scurf, which can be removed in a powdery form; farther back, larger scales are formed. This is cured, by cutting and shaving the hair, and brushing the head daily with a hard brush, and washing



it with soap and water. If neglected, ulcers may form, and the disease be converted into the one next to be described.

#### SECTION EIGHTEENTH.

The porrigo is a collection of pustules, containing a yellowish coloured fluid, something in colour and consistence like honey, and ending in a white or yellow scab. The pustules are numerous, forming about the roots of the hair; they are itchy and contagious. They are not unfrequently accompanied with an eruption on the face, and other parts of the body, which has been taken for the itch; and indeed this disease has been called the scabies capitis. But the pustules are larger and more solitary than those of the itch, contain a straw-coloured thick fluid, and form crusts, which, especially on the hands, are flat and ragged, and resembling, in miniature, the scabs on the head. On the body there will be found many small pustules or pimples, with a red base and lymphatic top; and these also appear on the face, which is seldom the case in itch. Often about the back of the neck, the skin is very red, with small scabby pustules. Sometimes scabs form on the face, especially on the chin, similar to those on the head. Many rank the crusta lactea with porrigo, and consider both as scrophulous. It differs from the pityriasis or dry scab, in being pustular and humid. In order to cure this disease, it is useful to remove the hair. This has been proposed to be done, by pulling it out, by means of a pitch plaster; a method certainly effectual, but not very gentle, and never necessary. In mild cases, it will be sufficient to cut the hair very close, and apply a poultice or some emollient ointment, to loosen the scabs, and set free the hair. The head is then to be washed with soap and water, and as much of it shaved as can be done; and thus, by a repetition of the process, at the same time that proper applications are made, the whole head may at last be cleared. If, however, the disease be more extensive and obstinate, some depillatory \* may be employed; but this is rarely required. For this purpose, a combination of the ung. picæ, and white helle-

\* Quick-lime is sometimes employed for this purpose, and enters into the composition of many of the oriental depillatories.

bore, has been proposed, and is recommended by Dr Underwood. It is to be rubbed warm upon the head, for near an hour at a time; and then a bladder is to be put over the the scalp, to prevent the cap from sticking. After three or four applications, the scabs, and even the hairs, are loosened, and these are to be removed by degrees; after this new hair will grow, without any scab at the bulb or root.

Various applications have been proposed, whether the hair be or be not taken out. Some employ lotions \*, others ointments. A very useful preparation is made, by combining the sulphur vivum, camphor, and oil of bays. This is a very effectual application, and ought to be applied morning and evening. Before each application, the parts should be washed with a weak solution of oxy-muriate of mercury, or muriate of ammonia or potash, or with soap and water, or a lotion composed of two drachms of sulphurate of potash, a drachm of soap, and six ounces of water. The ung. picæ and, ung. hyd. nit. are employed with advantage. Sulphur ointment with the addition of a little white precipitate of mercury, or the weak mercurial ointment have been likewise found of service. In some obstinate cases, caustic, or cantharides ointment, or ointment containing verdigris have been used; and afterwards lime-water, or solution of sugar of lead, have been applied to heal the scalp. Internally lime water, decoction of the woods, sulphur, and small doses of calomel, have been given, and all of them, I think, occasionally with benefit, though Dr Heberden remarks, that he has found little benefit from internal medicines. When an eruption like itch appears on the body, along with porrigo, it will be useful to wash the parts with lime-water alone, or with the addition of a little oxymuriate of mercury, or with a sulphurous lotion; or anoint the parts with camphorated liniment, ung. acid. nitr. ung. hyd. nit. or sulphur ointment, and use the tepid bath occasionally. Sea-bathing is of great benefit.

\* Dr Underwood recommends the decoction of tobacco, or lotio saponaceo; Dr Frank, urine; and Mr Barlow, the following lotion: R. kali. sulph. ʒiii; sap. alb. ʒiiss; aq. calcis, ʒviiss; spt. vini, ʒii. M.—Dr Heberden recommends the decoction of white hellebore.

## SECTION NINETEENTH.

The bloody scabs which are formed on different parts of the head, especially in the hollow near the neck, in consequence of vertigo, are cured by combing and washing the hair daily, and rubbing some mercurial preparation on the scabs; whilst an ointment, composed of oil of bays and staves-acre, should be rubbed over the scalp among the hair, or the powder of staves-acre may be dusted in among the hair.

## SECTION TWENTIETH.

Many children are subject to boils or inflammatory pustules, which have received different names according to their size and contents. We may chiefly notice two kinds; those containing pus, and those containing a more solid substance, which suppurate very slowly. The first are properly called pustules, and they are of different sizes. They generally are attended with a considerable degree of inflammation, and end in suppuration. The small abscess bursts, and a little scab forms, after which the inflammation dies away. Such a pustule has been called ecthyma, or sometimes terminthus. It requires in general little treatment, except the application of some soft ointment when the situation permits it. But if the pustules be numerous, as is often the case, after small-pox and other acute diseases, it will be necessary to use bark and the cold bath, especially sea-bathing; and the most painful and largest pustules may be hastened on by a poultice. The bowels are to be kept open.

The second are a kind of tubercles, called also boils, and by some are divided into the furunculus or acute boil, and the phyma, which is rather more tedious. They are hard, with an extended base, are usually flat, and of a purple colour. These, like the pustules, are sometimes solitary, and often large; occasionally, though not very frequently, they are scattered in great numbers over the body. It is proper to apply a poultice of bread and milk, or of boiled



turnips, until the top open, which happens sometimes by a kind of sloughing. Scarcely any matter is discharged, but a white or yellow core is found within, which is gradually thrown out, and then the boil heals like a pustule. During this process the ung. resinosum forms a very proper dressing, and sometimes the application of precipitate accelerates the separation.

There is a kind of small and very itchy pustule, beginning with a black spot on the skin, and containing a sebaceous fluid, which can be squeezed out in a worm-like shape. Such pustules have been called crinones, and were supposed to proceed from worms. They have been cured by washing with soap lotion, and applying ung. hyd. nit.

#### SECTION TWENTY-FIRST.

Purpura, or petechiæ sine febre, is a disease not uncommon with children, particularly those who live in confined houses, or are fed on poor or improper diet. It consists of an eruption of small purple spots, which are circular, not at all elevated, seldom larger than the diameter of a coriander seed, more frequently of the size of the head of a pin. They are scattered over the whole body, and even over the hairy scalp. They come out suddenly, without any fever or apparent indisposition, and go off slowly. They are not in general attended with foul tongue, spongy gums, or foetid breath; and the fæces do not become unnatural, but they sometimes are so before the disease takes place, and the belly may be very tumid, but these are not essential symptoms. By good diet, the use of acids, and removal to the country, together with moderate exercise in the open air, this disease is easily removed, or sometimes it goes off without any particular change being made in the mode of treatment. I have never seen this disease affect children till after they were weaned. This eruption is sometimes intermixed with hard papulæ, which forms a disease described separately, under the name of lichen lividus, by Dr Willan. These continue for a considerable time, and end by slight exfoliation of the cuticle, but afterwards may be succeeded by a

new crop. No peculiarity of treatment is required. A worse species of this disease affects children as well as adults, and attacks more slowly. For a considerable time before the spots appear, the patient is languid, and feels uneasy at the stomach. Then red spots, larger than in the former species, appear on the extremities, especially the legs, which are painful before the eruption comes out. The body is next affected, and the spots very soon become livid; sometimes vibices are also observed on the skin. This disease is attended with frequent and daily hemorrhage from the nose, mouth, alimentary canal, or vagina, and sometimes even from the toes. This species occasionally proves fatal, but it is often cured by the use of bark, wine, acids, good diet, and country air. It is, however, frequently very tedious. In worse cases, and in feeble children, the disease often begins with livid blotches on the scalp, which presently have the skin abraded; and then we may find some of them moist, and discharging blood or bloody matter; others dry, but without any scab or a cuticle; others covered with a thin black crust. Gangrenous sores form behind the ears; and the gums, especially near the symphysis of the jaws, become foul, and covered with brown lymph. An eruption of petechiæ then suddenly appears, and the child generally dies.

#### SECTION TWENTY-SECOND.

Erysipelas\* sometimes affects children, and even infants very soon after birth†. This disease appears to have been noticed by Avicenna, under the name of undimiam, or humid erysipelas, and afterwards at different times by other writers; but was first accurately described by Drs Underwood, Garthshore, and Broomfield. Dr Underwood

\* Erysipelas is attended with fever, and the part affected is red and hot, with soft diffused swelling. The redness disappears when pressure is made with the finger, but immediately returns when that is removed. There is a tendency to the formation of vesicles, which bursting, form either scabs or troublesome ulcers.

† Dr Underwood says, he once saw a child born of healthy parents, with sublivid inflammatory patches, and ichorous vesications, about the belly and thighs; but by the use of bark, and especially the mother's milk it recovered.

conceives, that it rarely makes its attack after the child is two months old, oftener a few days after birth. Dr Broomfield, however, saw it in a child much older, and I have met with the same circumstance. It makes its attack in general quickly, and the worst kind begins about the pubis, and spreads along the belly and down the thighs. There is not a great swelling, but the parts become hard, purple, and often end in mortification; so that the parts of generation drop off. This kind most frequently proves fatal, the peritoneum and intestines partaking of the disease. A milder kind, which I have met with much oftener, begins about the hands and feet, or not unfrequently the neck or face; and it is worthy of observation, that this frequently ends in suppuration; and on the neck especially, a very large collection of matter may be formed. Flour, or chalk is proper, as a local application; or if the heat be great, a cloth wet with weak solution of acetate of lead, may be safely applied. If suppuration take place, the matter should be early let out, and the parts gently supported with a proper roller, applied over mild dressings. The strength is to be preserved by means of a good nurse, and giving cordials, as for instance, white wine whey. In the worst kind, the early application of camphorated spirit of wine has been recommended with great propriety by Dr Garthshore. Ammonia, given early in doses of from five to ten grains every three hours, has been of service; but I have derived more advantage from calomel, in such doses as to act on the bowels, than from any other medicine. Green foetid stools are generally brought away. Bark has also been given, but the precise degree of advantage derived from this medicine in infantile diseases is not yet fully ascertained.

Erythema, according to nosologists, differs from erysipelas, in not being attended with the same diffused swelling, nor having the same tendency to form vesications; neither is it preceded or accompanied by any regular fever, though the system may be occasionally disordered during its appearance. In some cases, the inflamed part seems at first to be rough, as if covered with innumerable papulae, but this ap-



pearance presently goes off. The treatment is nearly the same as in erysipelas. Sometimes small irregular erythematic patches, accompanied with œdematous swelling, appear about the joints, eye-lids, or different parts of children\*, with fretfulness or feverishness. They in general require only to be kept clean, by being bathed with tepid milk and water, and dusted with some cool absorbent powder, or bathed with vinegar. Calomel is of service, and should be given pretty freely.

After the cow-pox, erythematic patches sometimes appear, not only on the arm, where the inoculation was performed, but even on more distant parts. This is most apt to take place after the vesicle has arrived at the height, or is on the decline. The inflammation sometimes ends, if not in gangrene, at least in a livid state of the parts, with fatal debility. Spirituous applications are then of service. When the part becomes livid, the strength must be carefully supported, and the bowels opened. In the commencement of this affection, saturnine lotions are proper, and often remove the disease. Calomel is useful. Dr Willan describes this as a species of roseola.

There is a species of erythema, erythema nodosum of Dr Willan, in which the patches are raised toward the centre. This elevation takes place gradually. In a few days, hard and painful tumors are formed, which threaten to suppurate, but they presently subside, soften, and end in desquamation. These are most frequent on the shin, but they may affect any part of the body. Laxatives are proper.

#### SECTION TWENTY-THIRD.

Excoriations frequently take place behind the ears, especially during dentition. The skin under the lap of the ear is covered with small pustules, and the inflammation extends from one to another. Sometimes a kind of erythematic inflammation takes place without pustules, and ends in vesica-

\* The erythematic patches produced by the bites of bugs, &c. in those whose skin is delicate, are distinguished by having a small mark or speck in the middle.

tions, which discharge thin matter. This complaint is not generally dangerous, but it is sometimes troublesome, and causes swelling of the lymphatic glands about the jaw and neck. Occasionally, however, the parts become first livid, and then gangrenous; and in such cases the child generally sinks, even although the sloughs begin to separate. In mild cases of sore ears, it is seldom necessary to do more than wash the surface frequently with milk and water, and apply a little lint spread with spermaceti ointment, mixed with the white oxyde of mercury. If the part be very itchy, and not healed by this application, it may be bathed with rose water, containing a little tincture of opium, or weak solution of acetate of lead; but astringent lotions, or such applications as tend to heal the surface speedily; if it have been long abraded or discharging much, are, unless purges be frequently given, justly esteemed dangerous, and apt to excite disease within the cranium, especially in those who are predisposed to convulsions or hydrocephalus.

If other applications are necessary, the citrine ointment, or liniments containing acetate of lead, calx of zinc, juice of scrophularia, cerussa, &c. have been employed.

When the parts become livid, or threaten to mortify, camphorated spirit of wine should be applied, and afterwards, when slough has formed, the fermenting poultice. The strength must be carefully supported. The bowels should be kept regular.

#### SECTION TWENTY-FOURTH.

The gums, about the time of dentition, or sometimes when the first set of teeth are shedding, become spongy and ulcerated, discharging a quantity of thin foetid matter. This at first may generally be stopped, by applying a mixture of muriatic acid and honey, in such proportions, as to taste pretty sour; or the parts may be frequently washed with equal parts of lime water and tincture of myrrh, or with a solution of sulphate of zinc.

If neglected, the ulceration becomes either fungous, and is

called scorbutic \* ; or sometimes of the kind which resembles sloughing phagedena, that is, a foul foetid spreading ulcer, destroying the gums, and in some cases the jaw-bone and cheek ; so that if the child survive, no teeth are afterwards formed in that part of the jaw. Occasionally, from the very first, this disease assumes a malignant form, beginning with some degree of inflammation of the gum, generally where the incisors should appear. The part is not swelled, but bright, and of a pale red colour, and this extends along the gums a considerable way. This soon ulcerates, forming a line along the gum, marked by white or brownish slough ; whilst exterior to this, the surface is inflamed, and this inflamed part next ulcerates ; so that inflammation precedes ulceration, till the mouth and cheeks be affected, and a large foetid sore formed, which soon injures the bones. This disease has been called the canker. It is attended with considerable discharge of saliva, and the breath is very foetid. Good diet, the internal use of acids, and great attention to cleanliness, at the same time that we use acid or spirituous applications locally, are the most likely means of cure.

#### SECTION TWENTY-FIFTH.

Another corroding disease begins in the cheek itself, or the lip. It commences with some degree of swelling, which is hard, and firm, and shining. It generally begins on the cheek, which becomes larger than the other, and the upper lip becomes rigid, swollen, and glossy. On some part of the tumified skin, generally on the cheek, we observe presently a livid spot, which ulcerates and spreads, both laterally and downwards. Being generally seated near the mouth, it soon reaches the gums ; and even the tongue partakes of this disease, which is of horrible aspect. We often find a great part of the upper or under lip destroyed, perhaps only a flap or portion of the prolabium left, all the rest being eaten away. The gums are foul, the teeth loose, the tongue thick-

\* In this case, some have recommended stimulants and astringent lotions, others compression. M. Berthe advises the part to be cut off ; and Capdeville proposes actual cautery.



ened, partly destroyed, and lying so close on other diseased parts, that we cannot say what is tongue or what gum, except by the child moving the tongue; and the mouth itself is filled with saliva. The ulcer is foul, shews no granulations, but appears covered with a rough irregular coat of brown lymph. The surrounding parts are somewhat swelled: near the ulcer, they are hard and red; farther out on the cheek, they are paler, and have more of an œdematous look. These local appearances are accompanied with emaciation and fever, and the child is either restless, or lies moaning in a drowsy state. This disease often proves fatal; sometimes, indeed, the parts cicatrize, or the patient recovers after an exfoliation of part of the jaw-bone. This ulcer is best managed with stimulants, such as diluted muriatic acid, solution of nitrate of silver, camphorated spirit of wine, tincture of opium, &c. but sometimes it is necessary to give these up for a carrot or a fermenting poultice. The bowels are to be kept open, the strength supported by milk, soups, and wine; and acids, with ripe fruit, given liberally. Before ulceration take place, the best application is camphorated spirit of wine, or we employ friction, with camphorated liniment. A course of gentle laxatives is useful.

Another disease, destroying the parts, is called noma, which differs from the former, in destroying rather by gangrene than ulceration. It attacks chiefly the cheeks and labia pudendi of children, and begins with a livid spot without pain, heat, or swelling, or with very little; and is not preceded by fever. It ends in gangrene, which destroys the part, and the patient often dies in a few days. It is to be treated with stimulant applications, or a fermenting poultice, whilst opium and wine are given internally, with or without bark, according as the stomach will bear. A variety of this disease appears with scarcely any swelling, but the inner surface of the vulva becomes livid, and then sloughs; so that the whole of the nymphæ and the clitoris may be destroyed, and the labia seem lined with fœtid brown sloughs. This requires the same treatment. It sometimes takes place after the measles or scarlet fever, and may be conjoined with the

induration of the cheek or lip, previously described. It very often proves fatal.

#### SECTION TWENTY-SIXTH.

Aphthæ are small white specks or vesicles, appearing on the tongue, inside of the cheeks, and the fauces. They are extremely common, and almost every child has at one period or other an attack. This disease appears under two forms. The mild, in which the eruption on the mouth is slight, and the symptoms comparatively trifling; and the severe, in which the local disease is extensive, and the constitution greatly affected. In the first or milder form, a few scattered spots appear on the mouth, as if little bits of curds were sticking to the surface of the tongue, or within the lips. These in a short time become yellowish, and then fall off, but may be renewed for three or four times. They leave the parts below of a red, or pink colour. The child, in this complaint, is generally somewhat fretful, the mouth is warmer than usual, and the bowels rather more open, and sometimes griped, which has been attributed to an acid state of the saliva. The stools are altered in their appearance, being green, or containing undigested milk, or of an offensive smell. There is no fever or general indisposition, except what may proceed merely from irritation of the bowels. It is most frequent within the first month, but may occur later.

In the severe or worst form of this disease; a fever\* even of a contagious nature precedes, or attends the aphthæ, and the child is sometimes drowsy and oppressed for some hours, or even a day or two before the spots appear, and occasionally is affected with spasms. The fever and oppression are often mitigated on the appearance of the aphthæ. The eruption is pretty copious in the mouth, and may become confluent, so that almost the whole surface is covered with curdy looking matter. The stomach and bowels are very much disordered, and the child vomits and purges. The stools are generally green, sour smelled, and sometimes acrid, so that the anus is

\* Dr Underwood is of opinion, that fever very rarely attends aphthæ, when it appears as an original disease.

excoriated. The aphthæ may not be confined to the month, but may descend along the trachia, producing cough, and great difficulty of breathing; but much oftener they go along the œsophagus to the stomach, which becomes very sensible, is painful to the touch, and the child vomits speedily after sucking. The mouth is likewise tender, so that the child sucks with pain, and with difficulty, if the crusts become hard, the tongue being rigid. After a short time, the aphthæ change their colour, and begin to fall off; but they may be renewed, and the abdominal symptoms may increase, so that the child is exhausted, and dies. There are two sources of danger, in bad cases of aphthæ: the first proceeds from the disorder of the alimentary canal, which always attends the disease; and the second arises from the particular state of the system, connected with the local disease, as in malignant sore throat, and many other diseases. It behoves us then, in forming our judgment, to attend to the sensibility of the stomach and bowels, and pay attention to the egesta. Frequent vomiting, repeated thin stools with griping, and a tender state of the abdomen, with or without tumor, are very unfavourable; drowsiness, oppressed breathing, moaning, spasms, and great languor, with frequent pulse, are likewise dangerous symptoms. With regard to the local disease, we find, that if the spots be few and distinct, and become a little yellow, and then in three or four days fall off, leaving the part below clean and moist, we may expect that the eruption will not be renewed, or will become still more mild. But if the aphthæ turn brown or black\*, which last is not a common colour, the prospect is not so good, and is worse in proportion to the rapidity with which they change. The longer that the aphthæ adhere, the more apt are they to become brown; and the case is worse, than when one crop succeeds another more speedily. If the succeeding crop be more sparing than the former, we augur well, and *vice versa*. When the aphthæ fall off, we expect their renewal, if the parts below are parched and look foul. If, however, in

\* Sometimes mortification takes place, and even the palate bones have been known to suffer.



this state, the eruption do not take place, and the oppression, weakness, and drowsiness continue, the danger, of the case is increased ; and in such circumstances, it has been observed, if the eruption afterwards appear, the child is relieved. It is also unfavourable, if a new eruption come out before the former one be thrown off. When the aphthæ fall off, the mouth becomes very tender, so that the mildest fluids some times give pain. Occasionally a salivation takes place, and the inside of the cheek bleeds. Dr Armstrong remarks, that he has seen the tongue covered with a crust of aphthæ, and the cheeks and gums full of angry pustules, and little fungous excrescences.

Now with regard to the causes, we find, that this disease is produced by derangement of the stomach and bowels, excited by improper diet, exposure to cold, &c. and sometimes slight attacks are occasioned by giving spoon-meat too warm. The tongue and mouth sympathize very much with the state of the alimentary canal, in every period of life ; but in early infancy, the changes produced in the membranes lining the mouth, by derangement of the function of digestion, are great and sudden. Whenever the diet is deficient, or improper, or the action of the stomach is impaired, aphthæ are produced, especially during the first month ; afterwards, at least when the infant is considerably older, the tongue merely becomes foul or furred, when the digestion is injured. It is rather with the stomach than the bowels that the mouth at first sympathizes, but the bowels also are generally affected, either from a propagation of diseased action from the stomach to them, or from the operation of causes, directly on them, as well as on the stomach. Hence the stools are generally bad, when the mouth is aphthous, and hence a change of diet, or medicines, which stimulate and invigorate the whole tract of the canal, remove the affection of the mouth. If a child be brought up on the spoon, or the milk be bad, one of the most early indications of injury is the appearance of aphthæ, or white exudations on the tongue. Some particular states of the atmosphere would seem either to excite this disease, or predispose to it, for it is most frequent in damp

situations, and in spring and autumn; and Van Swieten tells us, that it is peculiarly prevalent in Holland. It would appear also to be produced by sucking an excoriated nipple; and on the other hand, an aphthous mouth may infect the nurse. It has been said by Dr Moss, that a healthy child, sucking a breast immediately after a diseased child, receives the infection; and I believe it to be the case.

In the treatment of aphthæ, the cause is often overlooked, and local applications are expected to remove the disease. The first object, however, is to remove the cause, which most frequently is resident in the stomach and bowels. For this purpose, strict attention ought to be paid to the ingesta; as many nurses, instead of bringing the child up at first entirely, or almost entirely on the breast, give spoon-meat, and that in too great quantity, and not unfrequently combined with an anodyne, to keep the child quiet. Emetics have been strongly recommended by Arneman and others, in this disease. A little of the *vinum ipecacuanhæ* may be employed, which is preferable to antimony. This may be given early in the disease, if it require interference with active medicines, or do not yield to mild laxatives; but if relief be not soon obtained, it should not be repeated. Gentle laxatives are highly proper, such as manna, *cassia fistularis*, or a little magnesia; indeed, Dr Underwood seems to trust chiefly to absorbents. A small proportion of rhubarb may, together with an aromatic, be occasionally added to the magnesia. Small doses of calomel may be given with advantage. The remedy I chiefly recommend is laxatives, such as rhubarb, magnesia, or calomel, given so as to evacuate all offensive matter, and excite the action of the whole canal. The operation is to be gentle, but must perhaps be repeated for some days. Emollient clysters, made pretty large, and without stimulating ingredients, are likewise useful. Milk or soup may also be injected, to support the strength, when the child does not suck or take food by the mouth. If, however, the child have a purging, then we must proceed according to the directions which will be given respecting diarrhœa. In the worst species, we must

very early give a gentle laxative, or a mild emetic, if the child be much oppressed; and afterwards the bowels must be regulated, and medicine given according to the appearance of the fæces, and the state of sensibility. Nourishment is to be given carefully, or if the child cannot suck, clysters must be administered twice a-day. Where the debility is considerable, the strength must be supported by cordials, such as white-wine posset. The bark has been recommended when the debility is great, and especially when the mouth has a sloughy gangrenous appearance, or tendency thereto. Children, however, cannot take it, so as to do good; and therefore, when it is employed, it should be in the form of clyster mixed with starch\* or mucilage, but I cannot speak decidedly as to its benefit. Small doses of calomel, with opiates, are useful.

Local applications have been always employed, and in slight cases are trusted to by the nurse, without any internal medicine. The most common remedy is borax, in the form of a saturated solution in water, or mixed with honey or syrup; or a little of the powder may be put into the mouth, and it seems to have a better effect than could be expected from its sensible properties. It cannot, however, as Dr Bisset observes, be expected to remove the aphthæ until they are about to separate, when it ought to be employed, and may prevent a renewal. Until this period, a little veal soup, or white of egg beat up with water, may be given. Van Swieten recommends syrup of turnips. Applications which force off the aphthæ prematurely, do harm to the part, and seem to produce a renewal of the exudation. A solution of the sulphate of zinc, or diluted muriatic acid have been proposed as lotions, and may occasionally be of service; but it is highly improper to wash the mouth roughly, with a cloth dipped in these or any other lotions.

#### SECTION TWENTY-SEVENTH.

Aphthæ sometimes appear on the tonsils of children and

\* From a scruple to a drachm of bark may be given to a young child, mixed with half an ounce of fluid. Sometimes a little laudanum may be added to the clyster, to make it be retained.



adults, with or without fever; and from an apprehension of the existence of a malignant sore throat, give much alarm. There is, however, very little inflammation, and no lividity of the parts; the fever is very moderate, the strength not impaired, and the aphthæ do not spread; but, becoming brown; presently fall off. This is cured by acid gargles and laxatives. Another kind of sore throat is attended with the usual symptoms of inflammation, accompanied with an exudation of tough yellow mucus. It yields readily to the same treatment.

#### SECTION TWENTY-EIGHTH.

About the the time of dentition, the tongue, gums, and inside of the lips, are sometimes spotted over with superficial excoriations. They are seldom larger than a coriander seed, of an irregular shape, and covered with yellow or brownish mucus, adhering so firmly, and being so thin, as to resemble the solid base of the sore itself. They are tender, and generally accompanied with salivation. They are cured by being touched with alumen ustum, or lightly with a pencil, dipped in weak solution of nitrate of silver. Borax also or tincture of myrrh, seem to do good. But perhaps these would always heal easily, if left to follow their own course.

#### SECTION TWENTY-NINTH.

Infants may be affected with syphilis, in different ways. They may be diseased in utero; in consequence of the state of one or both of the parents. They may be infected by passing through the vagina, when the mother has chancres; or by sucking a woman who has the nipple affected. Of all these methods, the first is the most frequent; and it is worthy of remark, that this mode of infection may take place, when neither of the parents has at the time any venereal swelling or ulceration, and perhaps many years after a cure has been apparently effected. I do not pretend to explain here the theory of syphilis, but content myself with relating well established facts.

In such cases, it is very common for the mother to mis-

carry, or have a premature labour, without any evident cause; and when this takes place, the child is found to have the epidermis wrinkled, or peeled off, as if it had been macerated, and sometimes deeper ulcerations are discovered. The liquor amnii is turbid and foetid. We are not, however, to suppose, in every instance where these appearances are met with, that the child is syphilitic; for any cause, producing the death of the fœtus, a considerable time antecedent to its expulsion, will produce nearly the same appearance. The diagnosis then, must depend much upon the repetition of the premature labour, the circumstances attending it, the history of the parents, and the distinct appearance of ulceration. In such cases, the parent originally affected ought to undergo a mercurial course; and if the other parent have any suspicious symptoms, mercury should be administered to both. Sometimes the disease seems to wear itself out, without any remedies being employed; and the children, born in future, are healthy. But it often happens, that the child, though it have received the venereal disease in utero, and probably possessed it as a peculiarity of constitution from the time of conception, is born alive, and has even no apparent disease on the skin, or in the mouth. Frequently, indeed, it is born before the time, and perhaps it has been preceded by one or two dead children. It may be clean and healthy, and continue so for even a month or two, but oftener it is feeble, and rather emaciated; and sometimes it has at the time of birth, or soon afterwards acquires, a wrinkled countenance, having the appearance of old age in miniature, so very remarkably, that no one who has ever seen such a child can possibly forget the look of the *petit vieillard*. In such a case, the child has scarcely any hair upon the head, but may have pretty long hairs on the body; it cries in a low murmuring tone, and appears so weak, that it cannot suck for a minute at a time. But whether the child be apparently healthy or emaciated at the time of birth, other symptoms presently appear<sup>1</sup>; and of these, the most frequent and earliest is generally an inflammation of the eyes, accompanied with ulceration of the

tarsi, and purulent discharge. This appears a few days after birth. The eye presently, if neglected, becomes ulcerated, and the cornea opaque. Copper coloured blotches, ending in ulceration, appear on the surface; or numerous, livid, flat, suppurating pustules, cover the surface; or many clusters of livid papulæ appear, which presently have the top depressed; and then end in ulceration. These papulæ are sometimes attended by an eruption of pale shining pimples on the face, which enlarge, become red, and often run together. Children have sometimes an eruption of herpetic looking spots, which I have formerly described; and which resemble syphilis. The syphilitic blotches are of a darker colour, are more apt to end in ulceration than in scurf, or to form crusts or scabs, and seldom disappear without the use of mercury; or if they do, they soon return, and become worse by continuance, and presently are combined with additional symptoms of the disease.

The genitals and anus<sup>2</sup> becomes ulcerated, and sometimes excrescences sprout out from these parts. Foul sores, having retorted edges, and a centre pale and like lard, cover the inside of the mouth; and chancrous ulceration takes place on the lips, especially about the angle of the mouth. These sores and chops are often surrounded pretty extensively with a whiteness of the skin; as if the part had been scalded, or recently rubbed with lunar caustic; and perhaps, from this circumstance, these sores have been called, though improperly, aphthæ. They may, however, be combined with aphthæ. In some cases, the white or dusky patches cover the whole palate and inside of the cheeks whilst the gums are ulcerated, or even nearly gangrenous. The ulceration of the gums has always a very angry look. The nostrils become stuffed, and discharge purulent matter. On the face and hands we see obstinate sores, covered with pus, others with crusts, whilst the intervening skin is sallow. The child is hoarse, and the glands of the neck, with those below the jaw, are swelled. Children, like adults, have in general the surface first affected, and then the mouth and throat. They seldom live long enough to have the bones



diseased. They are always in great danger, and those who are much diseased never recover. Mahon, with great justice, ranks among incurable symptoms, the old decrepid visage, great destruction of the globe of the eye, chaneres on the middle of the lip, spreading to the frænum, and extensive uleertion of the mouth. It must be remembered, that syphilis not only may appear under its own peeculiar characters, but may also exist under the form of some of the eruptions common to children; such as erusta lactea, herpes, psoriasis, &c. These are known to be venereal, by their being of a more livid colour than usual; they tend slowly to ulceration, and when the scab or crust with which they are furnished comes off, a foul honey-comb-like ulceration is observed below. But the best diagnostic is, that they are soon attended with other symptoms, such as hoarseness ulceration of the mouth and throat, &c. We must make up our judgment slowly, and with deliberation.

When a child is infected during delivery, the disease appears more promptly on the surface, in the form of ulcers; and the usual train of symptoms follow, the mouth and genitals becoming presently affected. The disease generally appears within a fortnight after delivery; sometimes so early as on the fourth day.

If the child receive the infection from the nurse, we discover ulcers on her nipples, and the disease appears on the child's mouth, before the surface of the body be affected.

It has been proposed to cure this disease by giving mereury to the nurse alone, but this method is now abandoned, mercury being given directly to the child; and it ought to be remembered, that this medicine produces less violent effects on the bowels in children, than in adults, and scarcely ever excites a salivation. But if given too long or too liberally, it may kill the child by its irritation, or may excite convulsions. Calomel is very often employed, and with great benefit, a quarter or half a grain being given three times a-day. Others advise frietions, which are equally useful. Fifteen grains of mercurial ointment are rubbed on the thighs alternately once in two days, until the mouth be found hot, when it is intermitted or continued, according to the state of the

system, and the effect on the disease ; it must be used till the disease be removed. It has been remarked, that children, apparently cured when on the breast, have had a relapse after being weaned. If the child be griped, a gentle purge, and then an opiate, will give relief. Some have used the ung. acid. nitros. in place of the mercurial ointment, but it is not to be depended on. It is, however, useful, as an auxilliary, when applied to the affected part of the surface. Sometimes, in consequence of the use of mercury, a peculiar eruption, called the *eczema mercuriale*, takes place. This generally begins on the lower extremities, and spreads to the body. It consists of very small vesicles, which at first are like papulæ. Each vesicle may with a glass be seen to be surrounded with redness ; and if they are not disturbed, they acquire the size of pin's heads, and then their contents become opaque. They are attended with heat and itching, and a general tumefaction of the part affected. Presently, even if not scratched, the vesicles burst, discharging thin acrid fluid, which stiffens the linen, and sometimes excoriates the part. When the discharge ceases, the cuticle becomes of a pale brown colour, and then blacker ; and separating in pretty large flakes, leaves the skin below of a right red colour. After this, the skin comes off in scales or scurfs, perhaps two or three times. The disease ceases of itself, sometimes within ten days ; often, however, it is protracted longer. Those parts which are first affected, are first cured. Relief may be obtained, by applying saturnine lotions, or weak saturnine ointment.

#### SECTION THIRTIETH.

The disease termed skin-bound, may be divided into the acute and chronic, the last being chiefly met with in private practice. The acute species generally appears soon after birth, and proves fatal in the course of a few days. The best description of this disease is given by Dr Underwood, and by M. Andry, as it appeared in the hospitals of London and Paris. In London, the children were seized at no regular period ; but it was observed, that, whenever the disease appeared, several children were attacked within a short time,

and especially those in the last stage of bowel complaints, in which the stools were of a clayey consistence, and of which the induration of the skin appeared to be only a sequel. The skin was of a yellowish white colour, like wax, and it felt hard and resisting to the touch, but not œdematous. It was so fixed to the subjacent flesh, that it would not slide, nor could it be pinched up. This state was found to extend over the body, but the skin was peculiarly rigid about the face and extremities. The child was always cold, did not cry, but made a moaning noise, and had constantly the appearance of dying immediately. In the French hospitals, the disease differed, in being more frequently attended with spasm, or tetanus, and always with erysipelas, especially about the pubis, which, though purple, was very cold. These erysipelatous parts rarely suppurated, but sometimes mortified. The legs were œdematous, and the children died on the third or fourth day, or at farthest, on the seventh day from birth. This disease differs, then, principally from that observed in this country, in being combined with erysipelas and tetanus, which are by no means essential symptoms; and perhaps the erysipelas of children has sometimes been mistaken for the disease called skin-bound.

In private practice, the disease appears under a more chronic, though not less dangerous form. The children affected, are generally delicate; and in such cases as I have seen, the skin, from birth, was not so pliable as it generally is, being most rigid about the mouth, which had more of the orbicular shape than usual. The skin gradually becomes tight, hard, and shining, and of a colour a little inclined to yellow. In some cases, the whole skin is thus affected; in others, chiefly that about the jaws, neck, and joints. The scalp is often bald and shining, and the veins of the head peculiarly large and distinct. In some instances, parts of the skin are rough and slightly herpetic. The appetite, at first, is not greatly impaired, and the bowels are sometimes uniformly regular. Presently the child becomes dull and listless, and moans, and gradually sinks, or is carried off by fits. The complaint lasts for several weeks. In some cases, the disease



is less severe, the appearance of the child being healthy, and the thickening and rigidity of the skin confined to the joints of the extremities<sup>5</sup>. No light is thrown on the nature of this complaint by dissection, which simply discovers a deficiency of oil in the cellular substance, with induration. In the acute species, the liver has been found enlarged, and the gall bladder distended. Sometimes more children than one in the same family have been affected; and in such cases, they have been always of the same sex. A variety of remedies have been made use of, such as mercury, laxatives, baths, and emollient frictions; but seldom with any advantage. A course of calomel powders has, however, appeared to do good, when the affection is confined to the extremities. Decoction of sarsaparilla, with the frequent use of the warm bath, decoction of mezerion, and a variety of diaphoretics, might be tried; and in cases where more children than one in the same family, have been affected with the chronic species of this disease, it might be worth while to try the effects of mercury, and some other medicines, on the parents.

#### SECTION THIRTY-FIRST.

The small-pox begins with a febrile attack, which commences generally about mid-day. It is marked by chillness, listlessness, pain in the back and loins, drowsiness, vomiting, pain in the region of the stomach, which is increased by pressure, starting, and coldness of the extremities. As the fever advances, the pulse becomes more frequent, the skin hotter, the face flushed, the eyes tender, and the thirst considerable. The child starts, grinds his teeth, or has one or more epileptic fits, or sometimes complains of severe cramp in the legs, or lies in a kind of comatose state<sup>4</sup>. On the evening of the third, or morning of the fourth day, an eruption appears on the face, and then on the neck, from which it spreads to the body. In mild cases, the eruption is completed by the evening of the fourth, but sometimes not till the fifth day, or even later, if the pustules be very numerous; and then the fever declines, or goes off altogether. The eruption consists, at first, of small hard red pustules, of a fiery appearance.

On the second day, the top is clear, and a very small vesicle is observed to be forming. On the face, we frequently find patches like measles, but containing many minute vesicles. Next day, if the eruption is to be copious, the number of pustules is farther increased, especially on the face, where we often find more patches. These patches, and the succeeding confluent vesicles, seldom appear in the inoculated small-pox, or in the natural small-pox, when very distinct. They are numerous, in proportion to the tendency to the confluent form of the disease. The pustules on the body are more raised and rounder, though in some places they are flatter, and more extended. The base is surrounded with an inflamed rim; and presently, if the eruption be copious, this inflammation spreads from one pustule to another, so that all the surface appears to be red. The cuticle of the vesicle, at this time, is somewhat opaque, but its contents are limpid, like water. On the fourth day, if there be any patches on the face, they are evidently covered with flat confluent vesicles; on the body and arms, the vesicles are larger and rounder than the day before. The surrounding redness is a little paler, the skin of the vesicle is whiter, and more of the pearl appearance; so that, at the first glance, the eruption seems to consist of white elevations. The vesicles are full and smooth. On the fifth day, they are rather flatter. On the sixth day, the skin of the vesicles, on the body and extremities is drier and harder, and the contents still limpid; all those on the body are entire, but about the chin some have broken, and crusts are formed. If there have been patches on the face, these are now covered with flat vesications. On the seventh day, the vesicles on the body and extremities are of a dead white colour at the circumference, but more glossy, like candied sugar, at the centre. Their contents are a little turbid; more crusts are formed on the face. On the eighth day, the fluid on the extremities is whitish. On the ninth day, the crusts on the face are more numerous, and they begin to be formed about the bend of the arm, &c. The pustules on the extremities are whiter, as if filled with pus, but the fluid is thin and

milky ; the skin of the vesicles is thick. On the tenth day, the pustules on the face are covered with scabs, and many are formed on the extremities. On the breast, the vesicles are prominent, like two thirds of a sphere, but compressed, and have no redness around them. Many vesicles are empty, and covered with thin brown skin. Scabs are formed, by the skin becoming dry, hard, and brown, or sloughing. The contained fluid is partly absorbed, and partly effused by exudation, so as to add a crust to the slough of the vesicle.

When the scabs are picked off, about the seventeenth day, the base of the mark is in general elevated above the rest of the skin, but the centre is depressed a little below the margin. The colour is light red. On the twentieth day, the planes on the body and extremities are smooth, flat, or slightly scurfy, so that they somewhat resemble herpetic spots.

The process is not always regular ; for, in very mild cases, the suppuration is indistinct, and the scab thin ; the pustule dries without forming much matter, so that inoculators can scarcely get their lancet wet. This is a favourable condition. Sometimes the matter, though considerable in quantity, does not exude to form a scab, but is absorbed, and the vesicle remains for a time entire, forming what has been called *variola siliquosa*.

About the seventh or eighth day of the disease, when the pustules are numerous, the face swells ; but about the tenth or eleventh, it subsides, and then the hands and feet swell. It is also common, about the sixth or seventh day, for the throat to become sore, with sneezing, and some degree of hoarseness or cough ; and, in unfavourable cases, the secretion about the throat becomes tough and thick.

When the pustules are numerous, a return of the fever may be expected about the eleventh day. This is called the secondary fever ; but in mild cases it is very trifling, and does not last long.

Such is a general history of the distinct small-pox : but the disease may also appear under a different form, known



under the name of the confluent small-pox. In this case, the eruptive fever is more severe, attended with greater pain in the loins, and often with coma. It differs also from the former, which is of the inflammatory kind, in being of the typhoid type, so that sometimes petechiæ appear. The eruption comes out earlier, generally on the morning of the third day, and is sometimes preceded by erythematic inflammation of the face or neck. The eruption is copious, and at first, more like measles than small-pox; so that some practitioners have, at this stage, mistaken the one disease for the other. The pustules, which are not so much elevated as the variola discreta, become confluent, especially on the face; and though they may be confluent only on the face, yet those on the body are not of a good kind. They form matter earlier, do not retain the circular form, and, instead of having the interstices of the skin, where they do not coalesce, of a red colour, as in mild small-pox, these spaces are pale and flaccid. The coalescence is most remarkable on the face, which often seems as if covered with one extensive vesicle. The matter which these pustules form is not thick and yellow, like good pus, but either of a whitish brown, or black colour. Scabs generally form about the eleventh day of the disease, but these do not fall off for a length of time, and leave deep pits. The swelling of the face is greater and more permanent than in the former species, and the eruptive fever does not go off when the eruption is completed; it only diminishes a little, till the sixth or seventh day, when it increases, and often proves fatal on the eleventh.

The treatment of the distinct is different from that of the confluent small-pox. During the eruptive fever, the antiphlogistic regimen must be carefully enjoined, the diet must be light and sparing, the surface kept cool and clean, and the bowels loose. Emetics, at an early stage of the fever, are often serviceable, and it is generally proper to give laxatives. Epileptic fits are relieved by opiates and cool air. When the eruption is coming out, the cool regimen should still be persisted in, and the bowels kept open. After the pustules have appeared, the fever generally abates; and then, although

heat should be avoided, the cooling and purging plan need not be carried so far as formerly. But if the fever still continue, these means should be also continued. The diet must be sparing, and plenty of ripe fruit should be given. If secondary fever supervene, it is to be removed, chiefly by laxatives and cool air; or if there be oppression at the stomach, a gentle emetic may be given.

In the confluent kind, during the eruptive fever, the cold plan should be diligently employed, and cathartics are of essential benefit. When the eruption appears, the cooling regimen should still be persisted in, and both vegetable and mineral acids ought to be given freely. Bark is also proper, provided that it is not productive of sickness or vomiting. When the fever is aggravated, at the height of the disease, emetics have been sometimes given with advantage; but in general they are not necessary, and more benefit is derived from laxatives and clysters. Opiates are useful, for abating irritation; and wine, with nourishing diet, should be prudently given, to support the strength, which is apt to be completely exhausted under the constant fever and irritation. On this account also, it is necessary to restrain diarrhœa, when it is frequent, and adds to the weakness. Blisters have been advised as stimulants, but they are only useful when deep seated inflammation exists. Sometimes the brain seems to be affected, the head being pained, the eyes impatient of light, and the patient delirious. In this case, leeches may be applied to the temples, and a blister put on the head. When the lungs are affected, blisters on the sides or breast do good. When the stomach is very irritable, if saline draughts and opiates do not give relief, a small blister should be applied over the stomach. If the swelling of the face subside quickly, and be not followed by tumefaction of the feet and hands, blisters have been applied to the wrists, but sinapisms are better, though it is not decided, that either are of great utility. When the throat is much affected, and filled with viscid phlegm, gargles are of use, and sometimes a very gentle emetic gives relief.

If the eruption suddenly subside, cordials tend to bring

back a salutary inflammation; or if it altogether recede, the tepid bath, with ammonia, and other internal stimulants, will be proper. The boils and inflamed pustules, succeeding variola, are very troublesome, and sometimes prove fatal. When large, suppuration should be hastened with a poultice; when small, unguentum resinosum may be applied; or if they be indolent, gentle friction, with camphorated liniment, and bathing with laudanum, is of benefit. The strength must be supported, and, as soon as possible, sea-bathing should be resorted to.

The violence of the variolous disease is generally lessened by innoeulation\*, which was first introduced into this country in the year 1721. The operation itself is very simple, consisting merely in abrading the skin on the arm or leg with the point of a lancet, and then applying on the small scratch a little of the variolous matter, which should be taken early, as, when it is delayed until the pustules are collapsing or scabbing, it sometimes produces a spurious inflammation. By the third day, we are sure of success, by observing a slight redness on the arm at the incision, which resembles, from the coagulated blood, a little black speck. On the third or fourth day, the part is hard to the touch. The redness gradually increases for the two succeeding days, and then a small vesicle may be perceived. By the eighth, or at farthest the tenth day, the pustule has completely the variolous character. It forms a circular elevation, surrounded with circumscribed redness, and the vesicle is a little flattened on the top. The constitution, at this time, becomes affected; and the earlier that the eruptive fever appears, the milder in general is the disease. The character of the succeeding disease may, it is supposed, be foreseen, even before the eruption take place, or be completed, by examining the arm; and on this subject, Dr Adams has given us some remarks, which will be found in the notes<sup>5</sup>.

The safety of the practice of innoeulation is greatly increased, by having the system as free as possible from every

\* Innoeulation, even after exposure to infection, is capable of producing a mild disease.



diseased state; and, therefore, children are not inoculated during dentition, at least if they cut their teeth with any trouble. Very young children are not considered as favourable subjects; Dr Fordyce observing, that two thirds of those who died from inoculated small-pox were under nine months. If we have our choice, the best age is said to be from two to four years, but it is dangerous to wait so long, lest the child should take the casual small-pox; and Dr Adams informs us, that of three thousand children inoculated at the hospital in one year, two thousand five hundred were under two years of age, yet only two out of that number died. Full plethoric children should be frequently purged, and fed sparingly, before the operation. Some particular modes of preparation have been often employed, such as giving calomel or antimony, but these have very little effect. The chief attention ought to be directed to bring the body into a state of good health, if previously delicate, or diseased: and, on the other hand, if requisite, diminishing plethora and inflammatory disposition by the obvious means. After the inoculation, the bowels must be kept open, and all stimulants avoided; and when the eruptive fever commences, the antiphlogistic regimen is to be strictly practised, and often has so good an effect, that few or no pustules come out; or if they do, they do not mature, and we have no secondary fever. In general, the arm heals kindly; but when it forms a sore, it should be exposed to the air, or dusted with chalk; or if it threaten gangrene, it should be bathed with camphorated spirits, or tincture of myrrh.

#### SECTION THIRTY-SECOND.

As a preventive of the small-pox, the vaccine inoculation is now very generally practised. This is productive in general, of a very mild and safe disease, consisting of a single vesicle, forming on the place where the inoculation was performed. On the third day, the scratch is slightly red, and, if pressed with the finger, feels hard. Next day, the red point is a little increased, and somewhat radiated. On the fifth day, a small vesicle appears, but it is still more easily

seen on the sixth. This gradually increases, till it acquires the size of a split pea. The colour of the vesicle is dull white, like a pearl. Its shape is circular, or slightly oval, when the inoculation has been made with a lengthened scratch, acquiring about the tenth day, a diameter equal to about the third or fourth part of an inch. Till the end of the eighth day, the surface is uneven, being depressed in the centre; but on the ninth day, it becomes flat, or sometimes rather higher at the middle than at the edges. The margins are turgid and rounded, projecting a little over at the base of the vesicle. The vesicle is not simple, but cellular, and contains a clear limpid fluid, like the purest water. On the eighth or ninth day, the vesicle is surrounded with an areola of an intense red colour, which is hard and tumid. About this time, an erythematic efflorescence sometimes takes place near the areola, and spreads gradually to a considerable part of the body. It consists of patches, slightly elevated, and is attended with febrile symptoms. On the eleventh or twelfth day, as the areola decreases, the surface of the vesicle becomes brown at the centre, and is not so clear at the margin; the cuticle gives way, and there is formed a glossy hard scab, of a reddish brown colour, which is not detached, in general; till the twentieth day. When it falls off, we find a cicatrix, about half an inch in diameter, and with as many pits as there were cells in the vesicle. During the progress of the vesicle, there is often some disorder of the constitution; and occasionally, a papulous eruption, like *strophulus*, appears near the vesicle.

As security against the small-pox is not procured by spurious vaccine vesicles, it becomes necessary to study carefully the character of the genuine disease; which I have briefly described. A very frequent species of spurious cow-pox, is rather a pustule than a vesicle. It increases rapidly, instead of gradually. From the second to the fifth or sixth day, it is raised toward the centre, and is placed on a hard inflamed base, surrounded with diffused redness. It contains opaque fluid, and is usually broken by the end of the sixth day, when an irregular yellowish brown scab is formed. If the

vesicle be regular in its progress, and have pretty much of the general aspect of the vaccine vesicle, -but contains, on or before the ninth day, a turbid or purulent matter, it cannot be depended on; and the security will be still less, if the scab be soft. Besides these, Dr Willan has characterised three spurious vesicles. First, A single pearl coloured vesicle, less than the genuine kind; the top is flattened, but the margins are not rounded nor prominent. It is set on a hard red base, slightly elevated, with an areola of a dark rose colour. The second is cellular, like the genuine vesicle, but somewhat smaller, and with a sharp angulated edge. The areola is sometimes of a pale red colour, and very extensive. It appears on the seventh or eighth day after inoculation, and continues more or less vivid for three days; during which, the scab is completely formed. This is less regular than the genuine scab, and falls off sooner. The third is a vesicle without an areola. These forms of the disease do not give security against the small-pox; and it would appear that a vesicle, which is even regular at first, or which runs through the whole course with regularity, may fail to secure the constitution; for there are well authenticated cases, where the small-pox has thus succeeded the cow-pox. Professed writers on this subject, have enumerated three causes of failure. 1st, From matter having been taken from a spurious vesicle, or from a genuine vesicle at too late a period. The best time for taking matter is about the eighth day; and after the twelfth, or when it becomes purulent, it cannot be depended on; or the same effect will be produced by any cause which can disturb the progress of the vesicle. 2d, From the patient being seized, soon after vaccination, with some contagious fever, such as measles, scarlatina, influenza, or typhus. 3d, From his being affected, at the time of inoculation, with some chronic cutaneous disease, such as tinca, herpes, &c. The precise circumstances under which these causes produce their effect, or the degree to which they must be present in order to operate, have not yet been determined with certainty.

Even where none of these causes exist, and when the ve-



sicle runs its course with distinctness, it does, though very seldom, happen, that the constitution is not rendered unsusceptible of the variolous action. It were much to be wished, that some test could be discovered, by which the security could be determined. The constitution is often manifestly disordered during some part of the vaccine progress, and such children are most probably secure; but sometimes the disorder is too slight to be discovered, and therefore this sign is not to be relied on. We are also assured, that even when no constitutional disorder has taken place, the child is secured. Other means, then, have been resorted to, in order to discover if the system be affected, so as to have a complete change induced by the inoculation. These are two in number: 1st, If a second inoculation be performed on the fifth or sixth day after the first, a vesicle will arise as usual, but it will be surrounded with an areola nearly as early as the first one. 2d, If a second inoculation be performed any time after the twelfth day after the first inoculation, some degree of inflammation will be induced; but if the system have been affected, no regular vesicle will be produced. But the most satisfactory method is, to inoculate with small-pox matter, which produces most frequently a small pustule, generally totally unattended with constitutional affection; but sometimes, even although the constitution have been changed by the vaccine inoculation, a slight febrile affection may be excited, either without any secondary pustules, or attended by an efflorescence on the skin, or an eruption of small hard pustules, which disappear in about three days. It unfortunately happens, however, that parents in general do not think it necessary to adopt any of these means; and inoculators, perhaps, trust too much to their own power of discrimination, in determining how far a vesicle is capable of producing the desired effect. Some test is the more requisite as vaccination is often performed in a very careless manner, and by people ignorant of the character of the disease.

It has been said, that if a child, properly vaccinated, should afterwards take the small-pox, the pustules are papulous, or tuberculated, and do not suppurate, but end in desquamation.

I have, however, seen a very distinct case of suppurating small-pox, in a girl who, some years before, had gone through the vaccine process in the most satisfactory manner; of which I am certain, having attended her on both occasions. I do not, from these remarks, mean to depreciate the cow-pox; on the contrary, it is only by ascertaining the precise power of vaccination, that its full benefit can be derived to mankind: and although the warmest friends of this discovery must admit, that it is not always successful, yet it has hitherto failed in so few instances, that we must consider it as justifiable to rely upon it, and adopt it, in preference to the variolous inoculation. Experiments have been made to ascertain the effects of inoculation with a mixture of variolous and vaccine matter; and the result has been, that sometimes the cow-pox, sometimes the small-pox, have been thus produced. When a person is inoculated with variolous and vaccine matter at the same time, the incisions being very near each other, the vesicles enlarging, join into one; and matter, taken from the one side, will produce cow-pox, from the other small-pox. When a person is inoculated with the two kinds of matter at the same time, or within a week of each other, both diseases will be communicated to the patient, whether the incisions be near or remote, and small-pox pustules will be produced on the body; but they seldom mature, and the disease is generally mild. When, however, the variolous inoculation is performed more than a week, as, for instance, nine days before vaccination, the vaccine pustule becomes purulent, and sometimes communicates the small-pox even in a very bad form. When, on the other hand, variolous matter is introduced nine days after vaccination, its action is altogether prevented. From these observations, it follows, as an important conclusion, that when a child has been exposed to small-pox contagion, vaccination, though it may not prevent, will yet generally mitigate the subsequent disease.

It only remains to take notice of two objections to vaccination. The first is, that it is apt to be followed by a very sore arm. This, however, applies in a greater degree to small-pox: and in general, the vaccine sore heals, by being

dusted with chalk or hair powder; and even when tedious, seldom requires any other application. The second is, that it is followed by cutaneous diseases. But these occur seldom, than when the variolous inoculation was performed; for then inflamed pustules and boils, with herpetie and impetiginous eruptions, frequently succeeded the disease. Doubtless, children, after vaccination, may have *crusta lactea*, herpes, &c. but it does not thence follow, that these are the consequence of inoculation; and it is not unworthy of remark, that no new cutaneous disease has been produced by the introduction of the cow-pox.

#### SECTION THIRTY-THIRD.

The chicken-pox is a disease, sometimes mistaken for small-pox; and at one time, and by some authors, described along with it. It is preceded by eruptive fever, which continues for three days, and is marked by languor, loss of appetite, thirst, furred tongue, pain in the head, back, and limbs, sometimes pain the epigastric region, with nausea and vomiting. The pulse is quick, the face occasionally flushed, and cough and hoarseness may attend the disease. Convulsions also, in some cases, occur during the fever, or the child has tremors when asleep, accompanied with terrifying dreams, or he is slightly delirious. The eruptive fever does not always go off when the eruption appears, but may continue even till the third day of the eruption. In general, however, the symptoms are mild, and sometimes exceedingly trifling. The eruption commences on the back, or breast, and next appears on the face and head, which is not the order observed by the variolous eruption. Last of all, it appears on the extremities. The pustules very soon contain lymph, and by the fifth day are covered with scabs or crusts, which is earlier than happens in the variolæ. These drop off sooner than in small-pox, and very seldom leave any cicatrix. The eruption is attended with very considerable itching, in consequence of which the pustules are soon broken. The pustules are seldom or never confluent, and Dr Heberden never could count more than twelve upon the face, but we sometimes meet with many more.



In varicella, almost every vesicle, on the first day, has a hard inflamed margin. On the second or third, they are full of serum at the top; and those which are fullest of the yellow liquor, resemble small-pox pustules of the fifth or sixth day. On the third or fourth day, the shrivelled and wrinkled state of the vesicles which remain entire, give a different appearance from the variolæ; and on the fifth day, the presence of scab assist the diagnosis. It is proper, however, to add, that in some cases, I have found the pustules longer than usual of running their course, and the disease altogether, so like small-pox, that I would have been at a loss to decide on the nature of the disease; had not the rest of the children in the family had the chicken-pox at the same time in the usual form.

Such is the general description of this disease; but it consists of some varieties, which have very properly been separately described by Dr Willan, whose distinctions I shall retain. 1st, The lenticular. The eruption consists, on the first day, of small red protuberances, not exactly circular, with a flat shining surface, in the middle of which, a minute vesicle is soon formed. These on the second day, resemble miliary vesicles, are about the tenth part of an inch in diameter, and are filled with whitish lymph. On the third day, the extent is the same, but the fluid is straw-coloured. Next day, many of the vesicles are broken; and those which are not, have shrunk, and are puckered at their margin. Few are entire on the fifth day. On the sixth day, small thin brown scabs appear universally, in place of the vesicles. On the seventh and eight days, these turn yellow and dry, from the circumference toward the centre; and on the ninth or tenth day, drop off, leaving red marks without pitting. 2d, The conoidal. The vesicles rise suddenly, and have a hard inflamed border. On the first day, they are acuminate, and contain a bright transparent lymph. Next day, they are more turgid, the lymph is straw-coloured, and they are surrounded with more extensive inflammation. On the third day, the vesicles have shrivelled, have inflammation round them; if entire, contain purulent matter, if they have burst,

They are covered with slight gummy scabs. The scabs fall off in from four to five days, and often leave durable pits. A fresh crop of pustules comes out on the second or third day, and runs the same course with the first; so that the eruptive stage in this species in six days, and the last formed scabs are not separated till the eleventh or twelfth day. 3d, The swine or bleb pox. The vesicles are large and globated, but the base is not exactly circular. They are surrounded with inflammation, and contain transparent lymph, which on the second day resembles whey. On the third day, they subside and shrivel, and appear yellowish, the fluid being mixed with a little pus. Before the end of the fourth day, they are covered with thin blackish scabs, which fall off in four or five days.

The chicken-pox is a very mild disease, and requires no other management than keeping the bowels loose, and the surface moderately cool. The skin may be sponged with cold water, which diminishes the heat, and lessens the number of pustules, if done, during the eruptive fever; at a later period, it abates the itching. I have, especially in scrophulous children, observed, that if the bowels were neglected by the parents, and the diet was full and heavy, the pustules become much inflamed, and ended in sloughs, which left large and permanent cicatrices; and in some cases, boils and abscesses have occurred from the same cause.

#### SECTION THIRTY-FOURTH.

Urticaria, or nettle rash, may appear either as an acute or chronic disease\*. The first is most frequent with infants and children. It is preceded by languor, sickness, and fever, on the third day of which, but sometimes earlier, an itchy eruption appears, bearing a very exact resemblance to that produced by the stinging of nettles. It consists of irregular patches, slightly elevated above the surface. These are of a dull white colour at the centre, and red toward the margins, which are sometimes hard and well defined. The size and

\* Dr Willan notices five different species of this disease; but for the present purpose, this simple division is sufficient.

shape of the patches are very various. Generally they are about the size of a penny-piece, but sometimes form pretty long stripes. This eruption is, in some cases, attended by a slight turgescence of the skin, but especially of the face and eye-lids. The patches do not remain constantly out, but appear and disappear irregularly during the disease, which lasts for seven or eight days, including the period of the eruptive fever. When the eruption declines, the languor, stomachic symptoms, and feverishness, go off. The disease terminates by slight exfoliation of the skin. In infancy and childhood, it is often dependent on dentition, or affections of the bowels; and from the itching which attends it, great distress is produced. The febrile urticaria is not infectious, but in certain seasons it is very prevalent; and the same holds true with regard to the chronic species. Chronic urticaria is more rare in infancy. It differs from the former, chiefly in being destitute of fever, and vexing the patient at intervals for a length of time; sometimes even for years. The patches seldom continue out, however, for above a few hours at a time. They are, like the former, reproduced readily by exposure to cold, and are also particularly troublesome after undressing to go to bed. A temporary eruption of this kind, without fever, is often consequent to eating particular kinds of fish, or substances which disagree with the stomach. An eruption somewhat resembling urticaria, is described by Dr Willan, under the name of *roseola annulata*; it differs in size, and some other circumstances, whilst it agrees in others. It consists of circular patches, about half an inch in diameter, the margins rose coloured, the centre of the usual colour of the skin. These cover the body, and produce, especially at night, a sensation of heat and itching. When unattended with fever, the eruption fades in the morning, and becomes round and elevated at night. The use of acids, and sea-bathing will be of service.

A gentle emetic, followed by one or two purges, gives relief in acute urticaria. The child should, if possible, be kept from scratching, so as to tear the skin; and this will be the easier done, if he be preserved in an uniform temperature.



The tepid bath sometimes gives relief. The chronic species is more obstinate, and, in consequence of the abrasion of the skin, from frequent scratching, it has sometimes been treated as itch, but without advantage. The bowels are to be kept open by cream of tartar, and some tonic medicine should be administered. The tepid bath daily will also be proper, but sometimes, sea-bathing continued for some months succeeds better. Mercurials have been tried with very little good effect.

#### SECTION THIRTY-FIFTH.

Scarlatina may appear under two different forms. In the first, it is accompanied with inflammatory fever, and is generally mild; in the second, it is connected with a typhoid fever, and is very malignant. The first species admits of a farther subdivision, according to the degree of mildness; one variety being attended with slough or ulceration of the throat; another, still milder, with little or no affection of the fauces. This has by some been called *scarlatina simplex*, to distinguish it from the first, or *scarlatina anginosa*.

The *scarlatina simplex* begins with a febrile attack, attended with considerable debility, chilliness, nausea, and pain in the belly and about the loins and extremities. It generally attacks very suddenly in the afternoon or evening, the patient having been, not an hour before, lively, and apparently in good health. The pulse is extremely rapid, being often 140 in the minute; the trunk is very warm, and the feet cold; the respiration frequent, irregular, and sometimes sonorous; the eye sunk, and the eye-lids turgid and red on the inside. On the next day, if not earlier, an eruption appears, first on the face and neck, and very soon, always within twenty-four hours, it is diffused over the whole body. It consists of numerous minute specks, so closely set together, that the skin appears altogether of a red colour, like a boiled lobster, and it feels rough. Broad patches also appear on those parts which are most exposed to heat or pressure. The inside of the eye-lids, nostrils, cheeks, and fauces, are of a deep red colour, and the tongue participates in the appear-

ance. The eruption is most vivid at night, and especially on the evening of the third or fourth day. On the fifth day it declines, and is wholly gone by the seventh, when desquamation takes place. During the eruptive stage, the patient is generally either restless, or very drowsy, often slightly delirious, and both during this stage, and the process of desquamation, complains much of itchiness. Whilst the fever lasts, the skin is extremely hot. The contagion, in general, operates on the third or fourth day after the person has been exposed to it.

The scarlatina anginosa is attended with more severe symptoms. It commences with the usual symptoms of fever; and in general, whenever these appear, or even before the fever commence, the throat will be found, on inspection, to be affected; but sometimes the cynanche does not take place till the eruption come out, which is nearly about the same period as in the former species. Dr Sims says, that the first marks of disease are paleness and dejection of countenance, and that at this time the fauces will be found to be red. I am very much inclined to adopt the same opinion. From the first, there is a sensation of stiffness about the muscles of the jaw and neck, and very soon, generally on the second day, the throat feels as if straitened, the voice becoming hoarse, and sometimes a croupy cough takes place. In this case, the breathing often becomes sonorous, or even so obstructed that the child is suffocated, as in cynanche trachealis. In very many cases, deglutition is performed with difficulty, and sometimes the drink returns by the nose. On examining the mouth we find at the first, that the tongue has a very red colour, and its papillæ are evidently elongated. In the progress of the disease, it is often covered with a fur. The tonsils are early observed to be of a deep red colour, and very soon, whitish streaks may be discovered. Superficial ulceration is frequent on the second or third days, and the parts become covered with a white or ash-coloured substance, or slough, whilst the rest of the tonsil becomes of a dark red colour. The sloughs are sometimes not removed for a week or more, but often are detached on the fifth or sixth day,

when the cuticular eruption declines. The eruption, in this variety, is the same in appearance and duration as in the former. When it is slight, or disappears suddenly, it has been said that the event is hazardous, but this is not always the case. The fever is attended often with great nausea, bilious vomiting, restlessness, head-ach, and delirium. The heat is excessive, the pulse feeble, and sometimes fluttering, always very rapid. The languor and inquietude are great, especially when the sloughs are forming. About a week or ten days after the eruption fades, anasarcaous swelling of the legs may take place, and continue even for two or three weeks. Sometimes other parts of the body swell, or the patient has ascites.

Scarlatina is sometimes succeeded by pain in the ear, followed by temporary deafness, and the discharge of foetid serous fluid. This often abates, upon syringing the ear with decoction of chamomile for a few days; but it may be more obstinate, and the child remain permanently deaf. The tonsils occasionally suppurate, after the external disease abates. Swelling of the parotid gland is not uncommon; and it is said by various authors, when it is late of appearing, to protract or renew the symptoms, even the eruption itself; but this I have not witnessed. Sometimes the glands of the neck swell and suppurate, or the bones of the nose, after obstinate ulceration become carious. I have seen some unfortunate cases, where the lips have sloughed completely away, and these ended fatally. Even after the patient has, to all appearance, recovered from scarlatina, there sometimes unexpectedly supervene languor, debility, and pain of the bowels, frequent pulse and loss of appetite, which symptoms terminate in dropsy. Bronchitis or pneumonic affections may also be produced. In some cases, the patient becomes languid without fever or dropsy, but these generally do well.

In the second species, or scarlatina maligna, the pulse is very small and feeble, sometimes indistinct. The debility is very great, the patient fainting on making the smallest exertion. and very generally he is unable to sit up in bed. In the scarlatina benigna, the tongue is red, the eyes and eye-lids red, the



throat at first red, and the skin like a boiled lobster; but in this species, the tongue is livid, tender, and soon covered, together with the teeth and lips, with a brown or black crust, the eyes are dull, and the inside of the eye-lids dark coloured, the cheeks are livid, the throat of a dark red colour, with brown or blackish sloughs; there is foetid breath, with acrid discharge from the nostrils. The inside of the labia pudendi of girls, and of the prepuce of boys, has in scarlatina the same colour with the inside of the cheeks and lips; in the scarlatina maligna, the vulva and lips are of a dark colour, and sometimes mortify. The eruption is sometimes faint, in other cases very dark and purple coloured, and often appears and disappears irregularly. In the progress of this disease, delirium, great fretfulness, or coma may come on. The breathing is rattling, the neck seems to be full, and of a livid colour, and the head is bent back. This disease sometimes proves fatal in a few hours. It is not, however, always alike mortal, for there are several smaller degrees of malignity, forming a gradation betwixt this and the scarlatina anginosa.

The first species, when properly managed, is not very dangerous, but the last is attended with great hazard. The prognosis must be made, by attending to the symptoms of debility, the progress of the affection of the throat, the tendency to inflammation of the trachea, and the general character of the epidemic.

Drs Withering, Adams, and Willan, believe, that the scarlatina does not attack the same person twice, though the throat may be to a certain degree repeatedly affected. Although I have had many opportunities of attending to this disease, I cannot form a decided opinion on this important point; but I am rather inclined to adopt the same conclusion. Aphthous affections of the throat, and exudation of lymph from inflammation, are often considered as belonging to scarlet fever, though the eruption be absent, but the conclusion is incorrect. Those who are exposed to the contagion of scarlatina, may have sloughs in the throat, attended with considerable debility, but a regular repetition of the scarlet

fever is certainly not a frequent occurrence. Sometimes other eruptive diseases, such as a roseola infantilis have been taken for it.

The scarlatina simplex and anginosa, are often so mild diseases, as to require little medicine, but still great attention is necessary. When there is a considerable appearance of inflammation, venesection has been recommended; but this is very seldom necessary, often hurtful, and may almost uniformly be superseded by other means. Emetics, given early, are often attended with advantage, and render the subsequent disease milder. But laxatives are still more useful, and in mild cases are the only medicines which are required. In some epidemics, the bowels are moved with greater difficulty than in others, and in those cases the laxative must be stronger. Even when there is a tendency to diarrhœa, if the stools be foetid and unnatural in their appearance, purgatives are equally necessary as in the opposite state. The best medicine to be given at first, is calomel in a brisk dose, which often, even at the commencement of the disease, brings away foetid stools. This medicine cannot be used too early; and if an emetic have been given, calomel ought rapidly to succeed it. After the operation of the first dose of calomel, the bowels must be kept open, or even rather loose, by the daily use of infusion of senna with an aromatic. This is better than repeated small doses of calomel, which often affect the mouth considerably. But if the stools be very foetid, the patient oppressed, and the belly full, a brisk purgative may be given oftener than once in the course of the disease. Another remedy of great importance, is affusion with cold water. From careful observation, and repeated trials I can with confidence recommend this remedy, which by no means prevents the exhibition of purgatives at the same time. It is of consequence to use this early, and whenever the patient feels steadily hot, the shivering having gone off, and the skin feels very warm to the hand of another person, it is time to put the patient into an empty tub, and dash over him a large pail-full of cold water. By this I have known the disease arrested at once, the eruption never becoming vivid, and the

strength and appetite in a few hours returning. Even where it is not arrested, it is pleasant to observe the change it produces. The patient, from being dull, languid, and listless, feels brisk, and disposed to talk or laugh; the skin becomes for a time colder, and refreshing sleep is frequently procured. The repetition must depend on the degree of heat; one application is sometimes sufficient, but it often is necessary the first day to use it three times, and next day once in the morning, and again in the evening. It is seldom requisite afterwards; for although the disease may continue, it is mild, and laxatives complete the cure. Even an advanced state of the disease, if the bath have not been previously employed, and the skin is hot, does not preclude its use, though at this period, it is generally better to employ the sponge. On the contrary, it revives the patient. These two remedies do not only mitigate the disease, but lessen the risk of dropsical swelling taking place afterwards.\* Gargles are often useful, when they can be employed. Water, acidulated pretty sharply with muriatic acid, or mixed, with capsicum vinegar, forms a very good gargle. Acid fruits are proper. The diet should be light and nourishing. In mild cases, it is not necessary to give wine; but if the debility be considerable, small doses of wine may, toward the end of the disease, be administered. Should anasarca take place, laxatives and diuretics, such as digitalis, are proper.

The scarlatina maligna is much more dangerous, and requires the most vigorous practice. The early use of cold water is highly proper, and often gives a favourable turn to the future disease. Laxatives are likewise necessary; and so far from weakening the patient, if prudently administered, seem to increase his strength. Wine should be given, in such doses as do not flush the patient, or make him hotter. Ammonia is sometimes of benefit. Two drachms should be dissolved in six ounces of water, and the solution sweetened

\* Dr Hieglitz recommends in scarlatina, first, an emetic of ipecacuanha, and then so much Epsom salts as shall procure four stools. In bad cases, he gives four grains of calomel daily, or rubs in ℥ss of ung. hyd. Whenever the salivary glands become affected, the disease, he says, takes a turn.



with sugar. To infants, two tea-spoonfuls, and to elder children, from a desert to a table-spoonful of this solution, may be given every two hours, or oftener if possible. An infusion of capsicum in vinegar is also employed with advantage; so much of it is to be added to a given quantity of water, as renders it pungent. This mixture may be given in the same doses as the solution of ammonia, and it both acts as a general stimulant and as a local application to the throat. Bark has certainly, in many cases, been of service; but in general, children do not take it in such doses as to do much good; or they loath it or reject it by vomiting. Even when taken freely, I do not think that it is a medicine that can be depended on, in the cynanche maligna of children. When it is prescribed, it ought to be combined with ammonia or capsicum. Myrrh has also been given, combined with vinegar; but of the effect of this, I cannot speak from my own observation. Oxygenated muriatic acid in doses of twelve drops to children, has been employed; but I question if it produces better effects than water acidulated with sulphuric acid, which, if the ammonia be not employed, makes a very proper drink. If the patient, at an advanced period, be restless, and the skin dry and rough, ablution with tepid water will be useful. As gargles, capsicum vinegar with water, or muriatic or nitrous acid with honey and water, may be employed; but as children often cannot, or will not use gargles, it may be useful to throw these on the tonsils with a syringe. It is also proper to touch the sloughs and tonsils frequently, with a pencil dipped in the tincture of myrrh or camphorated spirit of wine. Fumigations, made by pouring sulphuric acid on nitre, placed in a vessel in the bed-room, have also a good effect on the throat. When the sloughs are large, or the child breathes with difficulty, or has a croupy cough, a gentle emetic of ipecacuanha sometimes does good, and ought to be tried. It is to be followed, if the child be a year old, by two grains of calomel every hour, till stools are procured. If less than a year, one grain may be given at a time. Blisters have also been applied to the throat, but I really cannot say decidedly, that they do

good, and they add greatly to the irritation of the child. In bad cases, there is risk of their being followed by mortification of the part: Sometimes, in the course of this disease, apoplexy succeeded by hemiplegia, and inability to articulate distinctly, takes place. Blisters should be applied to the head, and if the patient survive, the paralytic symptoms go off in a few weeks.

When a disease of this kind appears in a family, the children who are unaffected, ought if possible, to be sent away, and should not return for a month. In the mean time, the cloaths should be washed, and the apartment well ventilated, and fumigated with the vapour of oxygenated muriatic acid. This fumigation may be employed, even during the disease, for the destruction of the contagion, and of the smelling matter in the room.

#### SECTION THIRTY-SIXTH.

Measles commence with a distinct eruptive fever; on the first and second days of which, the patient complains of irregular shiverings, alternating with heat, general debility, languor, loss of appetite; has white tongue, thirst, pain in the back and limbs, slight sore throat, hoarseness, with dry cough and sneezing, weight and pain across the forehead, giddiness, drowsiness, frequent and irregular pulse, costiveness, and high coloured urine. On the third or fourth day, the symptoms become more severe; the eyes are tender, watery, and appear as if inflamed, the eye-lids are often swelled, the nostrils discharge thin serum; and the patient sneezes more frequently. There is now often some degree of dyspnœa, and sometimes pain and tightness in the chest. These febrile symptoms usually come on distinctly, about twelve or fourteen days after exposure to infection; but I have known children seized more gradually, being teased with hard cough, and rendered more irritable and fretful for many days before the eruptive fever commenced. The eruption appears betwixt the third and sixth day of the fever, but most frequently on the fourth. It is first visible on the forehead, then on the throat, then on the face. Next day

it appears on the breast, and by the evening it covers the trunk and extremities. The eruption consists at first of small red spots, apparently a little raised, like papulæ, but without vesicular tops. Then the spots extend so far as to form an oval or irregular figure; slightly elevated, but flat, resembling a flea bite. Very soon large patches appear, intermixed with the distinct spots. These are irregular in shape, but tend to the senilunar figure; they are made up of clusters of distinct spots. In some cases, the eruption, though vivid, is not considerable; and in this case, it consists almost equally of patches and circular and irregular spots, and the intervening skin is of the natural appearance. When the eruption is more copious, the patches are most numerous and extensive. In children under a year old, the eruption is not so thick and confluent as in older subjects, and in many places has a papulous appearance, especially on the face and hands. In some cases, the eruption, though of the usual configuration, is pale and indistinct; but in general, whether vivid or not, when the finger is passed over the surface, the skin feels unequal, from the elevation of the spots and patches. The colour is most vivid after the eruption has been out for a day. Sometimes the eruption suddenly and prematurely recedes, or never comes fully out. Both of these cases are unfavourable, the fever is high, and the oppression great. In the regular course of things, the eruption on the face fades a little on the sixth day, and next day that on the body becomes also paler\*. From this to the ninth day, the eruption is going off, and then the former situation of the rash is only marked by a slight discolouration. The departure of the efflorescence is attended with desquamation, during which the patient complains much of itchiness. The fauces in this disease, about the fourth day, are covered with small red patches, which next day have a scattered or streaked appearance. The inflam-

\* Sometimes, instead of this, the eruption becomes very dark coloured, or purple, with increase of the languor and fever. Mineral acids in this state are useful, and most children recover. The danger is greater when petechiæ appear among the patches, for this marks great debility.



ination of the eyes, sneezing, and hoarseness, generally decline with the eruption, and, towards the end, epistaxis sometimes takes place. The fever continues during the eruption, but the sickness and nausea abate when the eruption comes out, and about the sixth day the heat and restlessness go off. A spontaneous diarrhœa often terminates the fever, and then the appetite returns pretty keenly. Sometimes, especially if the disease have been severe, the measles are followed either by an eruption of inflamed pustules,\* over the body, which may ulcerate, and prove troublesome, but more frequently they fade, or by a vesicular herpetic-looking eruption about the mouth, or sometimes by gangrenous affections of the lips or vulva †, or by enlargement of the glands of the neck, or dropsy or a cough, somewhat resembling that in whooping-cough, or by hectic fever, continuing for many weeks.

Rubeola, in general, is not a fatal disease, when stimulants are avoided. When it proves fatal, it is most frequently in consequence of the pulmonic affection, sometimes of coma, or fever and oppression, with symptoms of effusion in the brain, connected with recession, or imperfect appearance of the eruption.

The treatment is extremely simple, and may be briefly explained. During the eruptive fever, the use of mild diaphoretics, and the tepid bath, will be of advantage. The bowels should be kept open, but the child should not be purged after the first day. If there be a considerable diarrhœa from extraneous causes, as dentition, or directly connected with the fever, it is often found that the eruption is late of appearing, and a late eruption is generally attended with some troublesome symptoms. A little rhubarb, given early, often moderates this.

\* These are sometimes taken for a kind of small-pox. They are occasionally succeeded by a scabby disease of the skin. The skin is inflamed and covered with rough loose yellow scabs.

† The measles, three years ago, were more prevalent than any practitioner I have met with, remembers them to have ever been before. They began about the middle of winter, and continued during the summer and autumn. I have had occasion, during the epidemic, to see different instances of the gangrenous affection I have mentioned. The children all belonged to the poor, and lived in confined lodgings.

If the eruption do not come freely out, or recede prematurely, and the child be sick, oppressed, and breathe high, we must attend first of all to the bowels. If diarrhœa exist, and the child be not plethoric, a little rhubarb should be given, and then spiritus ammoniæ aromaticus with laudanum, and the child should be put in a warm bath, having a little mustard diffused in it; afterwards a warm plaster should be applied over the stomach, and we determine to the surface by giving a saline julap. If in this state the child be constive, a gentle purgative should be given, for the bowels may be either too torpid or too irritable.

I have not advised the liberal use of purgative medicines, though these are found beneficial in scarlatina, because we often find that diarrhœa interferes with the eruption. But the bowels are upon a general principle to be kept regular, or rather open; and if the stools be fœtid or ill coloured, then, even although diarrhœa exist, small doses of calomel should be given, and afterward, if necessary, the purging is to be moderated by anodyne clysters. So far as I have observed, the continuance of the diarrhœa, in this case, does not mitigate the symptoms; and if the child recover, it is either by the use of medicines bringing the bowels into a better action, or it is independent of the mere evacuation produced by the diarrhœa.

If the pneumonie symptoms be considerable, marked by cough, oppressed breathing, flushed cheeks, and pain in the chest, which, in young children, may be discovered by the effect of coughing, and if a slight motion excite coughing, a blister should be applied to the breast; and if the child be robust, or the symptoms urgent, either one or two leeches may be applied at the top of the sternum, and moderate doses of calomel given to keep the bowels open. If the cough be frequent, without inflammatory symptoms, opiates give great relief; and if there be no diarrhœa, the acetum scillæ may likewise be given. Diarrhœa should not be checked, unless severe, and it increase debility, or produce other hurtful effects. Anodyne clysters are the best remedies.

Coma or drowsiness very frequently attend the measles, and the child may perhaps scarcely look up for some days. When the nostrils are stuffed with mucus, the breathing, in this case, has an alarming appearance of stertor. Most children recover from this state; but as some die evidently from this cause, and as we have no means of ascertaining the security of any individual, I hold it expedient to use means for the removal of the coma, particularly by giving a purge, if the child have not a looseness, and shaving the head, and afterwards applying either a sinapism or a blister. When the child is plethoric, it may also be proper to apply leeches to the forehead.

The cough which remains after measles, is generally relieved by opiates. Hectic fever is often removed, by keeping the bowels open, giving an anodyne at bed-time, carrying the child to the country, and adhering to a light diet. Other symptoms are to be treated on general principles.

When the measles are epidemic, it is not uncommon to find those who had formerly the disease, affected sometimes with catarrh \* without any eruption, sometimes with an eruption preceded by little or no fever, and without any catarrh. This has been very distinctly observed, during every season when the measles were prevalent. Whether the eruption be of the nature of measles, is not easily determined, but certainly the external resemblance is very great, in so much that this eruption has been called *rubeola sine catarrho*. It requires no particular treatment, and is only noticed because it is sometimes taken for measles, but does not prevent the patient from a second attack.

#### SECTION THIRTY-SEVENTH.

Sometimes an eruption, termed by Dr Willan *roseola* †, is taken for measles. The first species, *roseola æstiva*, has no

\* During the epidemic three years ago, ophthalmia has been extremely prevalent amongst both young and old.

† This he defines to be a rose coloured rash, without scales or papulae, variably figured, and not contagious. By some former writers, this term is applied to a disease resembling nettle-rash. Vide Lory, p. 398.—The appearance of *roseola æstiva* is extremely well expressed by Dr Willan in his plate.



small resemblance to rubeola. It is often preceded by chilliness, alternating with flushes of heat, languor, faintness, restlessness, occasionally with delirium or convulsions. At some period, betwixt the third and seventh day from the commencement of these symptoms, the rash appears, generally first on the face and neck, and afterwards in a day or two over all the body. The patches are larger and more irregular than those of the measles \*, in which the eruption consists of spots like flea bites, and patches made up of these spots; arranged sometimes in a crescentic form, and of a colour seldom deeper than bright scarlet, often much paler. In this disease, however, the eruption is at first red, but in general it soon assumes a deep roseate hue, from which Dr Willan gives its name. The fauces are tinged with the same colour, and the patient feels a slight roughness in the throat. The eruption appears first at night, and continues vivid next day, with considerable itching. On the third or fourth day, only slight specks of a dark red colour are observable, which next day disappear, and together with these the internal disorder. In some instances, the skin on many parts, becomes of a dusky colour, with an appearance of slight vesication, or desquamation. The drowsiness, sneezing, watery eyes, and running at the nose, so common in measles, are wanting in roseola, and there is no pulmonic complaint, whilst, at the same time, the patches are larger, and occasionally intermixed on the body with an appearance of nettle-rash. Sometimes the rash is only partial, appearing in patches, slightly raised above the surface, with a dark red flush of the cheek. This form lasts about a week, the rash appearing and disappearing occasionally; and usually the disappearing of the rash is attended with nausea, faintness, &c. In some cases, no fever is observable, or the progress and duration of the eruption is more irregular than I have described; and sometimes on the breast or trunk, the eruption has a great resemblance to urticaria, whilst on the arm, the appearance is de-

\* Sometimes young infants have an efflorescence of numerous coalescing patches, of a strong red colour, rounded, and of the size of a sixpence. These terminate in desquamation in less than a week.

*roseola faciei & buccae*

cidedly like roseola. The only treatment which is necessary, is giving gentle laxatives, the use of acids, and light diet. If the eruption be suddenly repelled, the warm bath is proper. Should there be a marked determination to the head, brisk purgatives are proper.

Another species, called *roseola autumnalis*, affects children generally in the harvest, and consists of distinct patches, of an oval or circular shape, which increase to nearly about the size of a shilling; they are not elevated, but are of a very dark colour, appearing, at a distance, as if a black cherry or brambleberry had been pressed on the skin, so as to leave the impression. The patches are not attended with fever, are usually diffused over the arms, and disappear in about a week. Acids may be taken internally.

The *roseola infantilis* appears during dentition, or in a disordered state of the bowels. It consists of a red efflorescence, usually very closely set, so that the surface is almost entirely of a red colour, as in scarlatina; but there is more appearance of patches than in that disease, and the other symptoms are wanting. The eruption generally goes off in a day, but it sometimes appears and disappears for several days, with symptoms of great irritation. No particular treatment is necessary, except what is required on account of concomitant circumstances. It is sometimes preceded or attended by vomiting or convulsions, with pale face and languor. In such cases a gentle emetic, the warm bath, and cordials are proper.

## CHAP. V.

### *Of Hydrocephalus.*

*HYDROCEPHALUS* is one of the most dangerous and insidious diseases to which children are subject. It sometimes makes its attack suddenly, cutting the patient off in a few days; sometimes more gradually, and is protracted for many weeks or months. It has, therefore, been divided into the acute and chronic; and as it may either appear as an idiopathic disease, or come on in the course of other diseases,

at first quite different, it may likewise be distinguished into the primary and secondary.

Acute hydrocephalus begins very like a common fever, but there is more frequent vomiting, and greater pain in the head, especially on one side; whilst in most other fevers of children, the greatest uneasiness is generally felt in the belly, the head being often unaffected. After the febrile symptoms have continued for some time, marks of oppressed brain appear, and the patient dies comatose, or convulsed. Such is the outline of the disease, which, however, it will be necessary to describe a little more minutely. Very often the patient, for some time previous to the attack, is languid, peevish, and uncomfortable, without any particular complaint. The appetite is impaired, he has frequent sick fits, or vomits bile, and the bowels are generally very costive, though sometimes he purges foetid, dark coloured, or green faeces, and he complains occasionally of his head. Towards evening, the face is a little flushed, and the skin is hot, and very soon the disease becomes formed. In other instances, however, and these by no means unfrequent, the disease invades more suddenly, or with scarcely any previous indisposition. The patient feels chilly, whilst his skin is hot; he complains greatly of his head, especially at the forehead, or at one side, sometimes very much of his neck. He cannot keep out of bed, his eyes are very sensible to the light, and, when examined, the pupils are contracted, sometimes irregularly, and the eye in some cases is troubled, in others as clear as usual. Spasmodic cough and pains in distant parts occasionally supervene. The head-ach is constant, and produces moaning, or the patient lies silent and unwilling to speak a word, or often even to take a drink. The stomach is very early affected, and for some days he vomits bile, and whatever he swallows; has no appetite, and little thirst; the tongue is white, the bowels generally costive; but sometimes loose, and the stools in that case green and foetid; pain is felt in the belly, and occasionally in other parts of the body. The sleep is broken, and frequently interrupted, as if the patient had a frightful dream; he starts,



grinds his teeth, and picks his nose, which makes the disease sometimes pass for the consequence of worms. The pulse, in a few cases, is not very frequent; but in general, especially if the disease be rapid, it is at first very quick, being about 120 in the minute. In about eight or ten days, the pupils are somewhat dilated, and the patient squints a little. In some cases, the vomiting is renewed, but more frequently it is not. The pulse at this time often becomes slow, beating only 60 in the minute, and being generally irregular. The pupil is more dilated, and the eye less sensible than formerly to light. The head-ach is usually diminished, but the patient frequently cries out, or even screams. In some cases, delirium comes on; in others, the patient continues sensible and intelligent, until the stupor supervene. More food is often taken, in this stage, than formerly. In the course of either two or three days, the pulse becomes again quicker, the pupil more dilated; but still the patient may continue to see, and complain of the light, and often answers distinctly every question. Presently, however, the symptoms of oppressed brain become greater, the pulse is weak, and gradually increases to 160 in the minute. The eye squints, vision is at last lost, the urine is either retained, or passed with the fæces involuntarily. The breathing becomes stertorous, and the patient dies. In the course of this malady, the cheeks are alternately flushed and palid; and after the second stage, one side is more or less paralytic, whilst the other in many cases is convulsed: indeed convulsions may come on at any period of the disease, even in its commencement. The symptoms are generally aggravated during the night. When the patient sleeps, the eye-lids are often only half closed, and the eyes turned up. He complains much, or becomes giddy, when the head is raised.

Hydrocephalus has been divided into three stages characterised by the state of the pulse and of the sensibility. In the first, the pulse is frequent, and the sensibility great. In the second, the pulse becomes slow, with marks of oppressed brain. In the third, it is again rapid, there is great debility and cerebral irritation. But it is to be recollected, that

these stages are not always well defined, for sometimes the pulse never becomes slow.

This disease runs on generally till the twenty-first day, if the patient be above two years old; but if the child be younger, it often terminates more speedily, sometimes so early as the fourth or fifth day.

From this account, it appears, that the symptoms, when the patient can describe them, are in the first stage much the same with those of the common fever of the adult, or many of the febrile diseases of children, and that upon these supervene those of oppressed brain. In some cases, however, water has been found in the ventricles when no symptoms indicated it during life \*, or when many of the usual symptoms were absent †.

Infants cannot give an account of their sensations, and therefore we are more uncertain, until the symptoms of oppressed brain appear. We may, however, dread the nature of the disease, when the infant has a high fever, vomiting, with costiveness or diarrhoea, lies oppressed, and apparently sick, with the eyes obstinately shut, dislikes the light, puts the hand frequently up to the temples, as if going to rub something off the head, has starting and spasms, and awakes suddenly as if terrified, and sucks or drinks at first with great rapidity. The diagnosis, it must however be confessed, is very difficult; for in disorders of the bowels, from dentition and other causes, spasms, starting, drowsiness, and strabismus, may take place ‡. It is perhaps prudent, whenever there is much fever, with any ambiguous symptoms, to proceed as if the patient were threatened with hydrocephalus, more especially, as the early use of the remedies thus indicated will generally be serviceable in the complaints with which this disease may be confounded; and if we de-

\* Vide Quin's Treatise, p. 43.

† Dr Rush mentions cases where there was no pain in the head, or where it began like a catarrh, or wanted the strabismus, dilated pupil, sickness, and loss of appetite. Med. Inq. Vol. II. p. 210.

‡ A very interesting case, where strong symptoms of hydrocephalus were produced by accumulation of feces, and a speedy cure obtained by purging with senna, is related by the late Mr Benj. Bell.—Hamilton on Purgatives, p. 217.

lay to the last stage, to obtain a more certain diagnosis, we have scarcely any hope of doing good. When children can give an account of their sensations, we may with great justice fear this disease, when they complain much of the head, have vomiting, and quick pulse.

Dissection shews that the vessels of the brain are full of blood, some of them very turgid, the membranes and brain in some places seem inflamed, and covered with coagulable lymph; whilst betwixt the dura mater and the brain\*, but still more frequently in the ventricles of the brain, there is an accumulation of water, sometimes to the extent of several ounces, and it is generally of a very pure and transparent quality. The abdominal viscera are sometimes inflamed.

Hydrocephalus is produced by causes, the operation of which cannot always be detected, but sometimes it can be traced to the sudden removal of an eruption, or cutaneous discharge from the scalp, blows on the head, &c. A scrophulous constitution appears to give predisposition to the disease. The term hydrocephalus is, perhaps, in one sense improper, as it expresses merely a symptom occurring in the end of the disease, and which does not exist whilst the disease is curable. No one thinks of calling pleurisy, émpyema, though that is a termination of pleurisy; it would be apt to call the attention of the practitioner to a different set of indications from those pointed out in the inflammatory stage.

The most proper treatment would seem to consist in the early application of leeches to the temples, and purging the patient with calomel; after which, the bowels are to be kept rather loose. These means should always be had recourse to on the very first attack of the febrile state, and in many cases will effectually check the progress of the disease, and prevent effusion. But if they do not immediately give relief, the head should be shaved, and a blister applied. If the patient has a diarrhœa instead of being costive, it ought

\* In this case the disease is called hyd. externus, to distinguish it from the species in which the water is in the ventricles, which is called hyd. internus.



not to be rashly checked; but if the stools be green, foetid, or contain lumps, doses of calomel should be given repeatedly. In the second stage, mercury combined with digitalis should be used freely, and repeated blisters applied to the head, so as to keep up a discharge. If the spasms are very frequent, opiates may ultimately be employed, as they will, at least, render the appearance less distressing to the relations. Such is the nature of practice in this disease; but when effusion has taken place, it is difficult to prove that medicine has any power over the malady. It is only in the very commencement that we can do good. If this period be lost, no future vigilance can regain the ground. I do then most earnestly intreat my reader to resort timeously to the application of leeches and smart purges which alone can subdue the morbid action which precedes effusion. If from a hope that the disease is of a less formidable nature; or from fear of giving unnecessary alarm in a case not decidedly dangerous; or from the still more inexcusable cause of inattention these means be neglected, how bitter is the reflection which arises in the mind, when symptoms of effusion appear. We cannot, indeed, by the most early and vigorous treatment always save our patient, but we can by this conduct always obtain the consolation of thinking, that we have faithfully done our duty.

When hydrocephalus is known to be a family disease, it will be proper to use every mean to strengthen the constitution, such as the cold bath, light nourishing food, and strict attention to the bowels. If the child be plethoric, the bowels should be kept loose, and a small issue may be inserted. We should be particularly careful not to heal too suddenly any eruption, especially about the head. The first symptoms of disease must be watched; and we had better be blamed for using remedies too early, than have to regret that we employed them too late.

The chronic hydrocephalus makes its attack more slowly, and runs its course with much less speed. It seems sometimes to be gradually approaching from birth, the child being dull, languid, subject to frequent fits of stupor or drow;

siness, and the head enlarging faster than it ought to do ; or it may even begin in utero. In other cases, the child is at first tolerably healthy, and it is many years before symptoms of the disease appear. First of all, we observe him to be duller than usual, with a slight degree of fever, attended with pain in the head, sometimes constant but moderate, sometimes attacking like paroxysms of head-ach, attended with sickness and vomiting. He is amused for a short time with the entertainments of his age, but is soon tired, and generally is found, after a little play, lying in a chair. The appetite is gradually impaired, and his food is apt to sicken him, or to be rejected by vomiting. The head-ach becomes more constant, and sometimes severe, often attended with giddiness, and pain or stiffness in the neck. The skin is rather hot, the pulse at first is frequent and irregular, though in some instances it very early becomes unusually slow, and continues so for a long time. The bowels are constipated, the urine sometimes passed with pain and difficulty. The eye is dull and languid, and at times the patient sees double or indistinctly. After these symptoms have continued some time, the bones of the head enlarge greatly if the sutures have not united, and the veins on the scalp become very distinct. The body wastes, and the muscular powers are more or less impaired. In this state, the patient may live many months ; or occasionally the disease seems to receive a check, and the patient lives for years with an enlarged cranium, and sometimes in a state of idiotism. In general, however, in a few weeks, or at most a few months, the symptoms of compressed brain become more distinct. The pupils are dilated, the patient squints, the limbs are paralytic and convulsed, the urine is suppressed, so that the catheter is required, the pulse full and slow, but presently it becomes weak and fluttering, and the patient dies comatose, with stertorous breathing. When the patient can give an account of his sensations, we may early be led to suspect some disease in the head, but in infancy we can receive no account of the sensations. We may discover it, however, by the unhealthy look of the child, the frequent application of the

hand to the head, the size and weight of the head, which are greater than usual, even before water be formed; drowsy fits, and sometimes convulsions; vomiting, and awaking terrified from sleep; at the same time that there seems to be no tendency to dentition. Afterwards the size of the head, and other symptoms, indicate the disease more decidedly.

There is an affection, which is liable to be confounded with chronic hydrocephalus. The patient complains of his head and neck for a length of time, has the pain increased by exercise, agitation, or reading long, and sometimes he squints. The pain, however, is rheumatic, follows the course of that disease, is not constant, and shifts its place. The squinting is either habitual, and consequently accidental, with regard to the disease, or it is caused by a temporary affection of the muscles of the eye, and is increased by looking long at any object. The patient is easily agitated, and, at a more advanced age, would be said to be hysterical. Laxatives, bark, and sea bathing, are useful.

On opening the head, we generally find a great quantity of water in the ventricles, and some even on the surface of the brain. Sometimes the ventricles are so much enlarged, that the cerebrum resembles two vesicles pressing on the cerebellum. The bones of the cranium are occasionally very thin and softened, sometimes very irregular on their inner surface. In a girl who died, after having been ill for about five months, I found the inside of the cranium, at the lower part, covered with sharp bony processes or spines.

The practice consists in the application of blisters to the head, or the formation of an issue on the scalp by means of caustic. The bowels are to be kept open, or at least regular, by the use of purgative medicines; and it will be proper to give a course of calomel or mercury, combined with digitalis, nearly in the same doses we would use for dropsy. By this plan, some children are cured, and others have the head reduced in size for a time\*. These have the urine consider-

\* In a case attended by my brother, he succeeded so far with the mercury and digitalis, as to render the fontanelle slack, whereas, before, it was tense and prominent. But whenever this slackness was produced, convulsions came on, and the patient died.



ably lessened in quantity; and when the medicines do good, they increase the flow of urine. It has been proposed, by bandages or other means, to support the bones of the head, and prevent distention, but of this I can say nothing from my own observation.

The secondary hydrocephalus is a very frequent disease, and is extremely insidious. The symptoms at first are quite independent of any affection of the head, and arise from dentition; disorders of the bowels, or other causes. But in the course of the disease so excited, especially if it be attended with fever, symptoms, indicating a diseased state of the brain, supervene with more or less celerity. That this should take place is not wonderful, when we consider the remarkable sympathy existing betwixt the brain and other organs, and the great vascularity of the brain, as well as its delicacy in children. But however the fact is to be explained, its existence is undoubted. It is unfortunate, that the first set of symptoms often fix the attention of the practitioner solely to the cause which is supposed to produce them, whilst the new disease is overlooked until all hope is at an end. It is highly necessary, in all diseases of children, to watch the safety of the head; and whenever symptoms appear, indicating an affection of that organ, to have recourse to the application of leeches, blisters, and other means, which have been pointed out. Indeed, in all protracted diseases of children, especially if attended with considerable fever, it will be prudent to shave the head, and apply a small blister upon it. Calomel purges are of great utility.

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## CHAP. VI.

### *Of Convulsions.*

CONVULSIONS proceed from various causes during infancy. They very frequently arise from irritation in the bowels, from dentition, or in the course of eruptive fevers. Sometimes they proceed from immediate affections of the brain itself, and very often they occur in hydrocephalus. They

may be distinguished into those proceeding from a primary affection of the brain\*, and those occasioned by sympathy with some other organ in a state of irritation. It is not, however, easy to make the diagnosis in every instance; and when convulsions continue long, whatever may have been their origin, the brain ultimately suffers; and if the disease be protracted, the patient becomes emaciated, and perhaps paralytic, or even hydrocephalus may very early be excited.

We may be assisted in our judgment, by examining the gums, especially if the child be about the time of life when teeth appear; by inquiring into the state of the bowels, whether they be loose or bound, or the child be troubled with worms; by learning if an eruption has suddenly disappeared: or if the child has been frightened, or had heavy food, or too much food, or been sucking a woman whose mind had been recently agitated; or if none of these causes be discovered, we should inquire if the child has already had those febrile eruptive diseases, which are often preceded by convulsions, especially small-pox. In at least nine cases out of ten, convulsions proceed from irritation of the bowels; the stools being generally unnatural, or the digestive functions impaired. This observation is of much importance in practice, as it points out both the means of prevention and of cure.

Very young infants are subject to a slight degree of spasms called inward fits, in which the mouth is, during sleep, drawn into a smile; the eye-lids are not quite closed, and the eyes are turned about, so as at times to discover the white; the breathing seems occasionally to flutter, and the child is very easily startled. These fits appear to be occasioned by wind in the stomach or bowels, for they are relieved by a discharge of wind, and require some carminative, such as sugar of anise, with a gentle laxative. They generally go off in a short time, but sometimes they are succeeded by vomiting or purging, or drowsiness, ending in convulsions.

\* An epidemic convulsion is mentioned as prevailing at one time in Paris, affecting children under eight years of age, and young whelps; in which blood was constantly found effused under the cranium. It proved fatal in seven hours. *Recueil Period.* Tom. IX. p. 286.

Some children, very early after birth, appear languid, moan, and pass dark coloured feces, different from meconium, and after it, in the usual course of things, ought to be removed. Presently they fall into a state, rather resembling syncope than convulsions, and die perhaps in forty-eight hours after they are born. The early use of calomel, in small doses, conjoined with some gentle aromatic, is proper.

Others, soon after birth, are seized with a violent fit of crying, and they become more or less distinctly convulsed, and the muscular irritation may repeatedly recur. This is relieved by the warm bath, gentle laxatives, and rubbing the belly with a little laudanum. I have sometimes thought that this state was induced by tying the cord too near the belly, by which an irritation was communicated to the abdominal viscera. Infants of a month old, who are subject to severe fits of crying from cholic, which is often induced by bad nursing, may be suddenly carried off by a convulsion after a violent and continued paroxysm of screaming. This state requires great attention to the bowels and to diet.

Regular convulsions may occur at a very early period of infancy, and in this case attack those children who, from the time of birth, have been subject to heavy sleep, or to whine and moan, or to violent screaming, or to start suddenly from their sleep, and who have twisting of the extremities while awake.

Convulsions vary much in their degree and duration. Generally the child is seized quickly with a spasm of the muscles of the arm and legs, which are agitated to and fro, the fists are clenched, the body bent back, the features distorted, the eye-lids open, the pupils dilated, and the eyes either fixed in the socket or rolled about. The face is either pale or livid. These convulsions may prove very suddenly fatal; but sometimes after the fit has lasted a minute or two, it goes off and does not return. In other cases, it returns very frequently for several days, or at uncertain intervals for many weeks. In general, the longer the fits, and the shorter the interval, the greater is the danger. The occurrence



of paralytic symptoms or emaciation, in those cases where fits are frequently repeated, adds greatly to the danger.

When a child is seized with convulsions, a very great alarm prevails; and it is expected, that if the practitioner arrive before the child is carried off, or has recovered from the fit, very prompt and active means must be employed. The first thing to be done, is to order a warm bath and a glyster to be got ready immediately; and while these are preparing, we inquire into the circumstances of the case, and examine the gums. If the child be at the time of teething, and no other cause be discovered, it will be proper to cut the gum freely over that part where the teeth ought, according to the usual order of dentition, to appear, even although no swelling be discovered. Then the child is to be put into the warm bath, the face alone being kept above the water, and he is to be retained there for a few minutes, if the fit do not pass off sooner. In some instances the addition of a little hartshorn or mustard to the bath is useful. When the child is taken out of the bath, a cloth is to be applied over the stomach, or great part of the abdomen, wet with strong spirits, and lightly sprinkled with pepper. A clyster is at the same time to be thrown up, so as to operate speedily; and this is to be followed by a calomel purge, and the subsequent use of laxatives, to keep the bowels open. Even if the child has diarrhœa, if the stools be not natural in appearance, laxatives will be proper, according to the directions given in considering diarrhœa\*. Emetics have also been employed during the fits; but unless we have reason to suspect that some indigestible or improper substance has been taken, they will not be so beneficial as laxatives. But when fits are only apprehended in dentition, from starting, feverishness, and circumstances ascertained by former experience to precede convulsions, a gentle emetic is often of service, and ought to be followed by the warm bath and some antispasmodic, such as asafoetida, conjoined with a lax-

\* The propriety of giving purgatives in convulsions, when the bowels are costive, or the stools unnatural, is confirmed by experience, and the effects of this course in chorea.

ative if necessary. Tincture of asafœtida, with the addition of oil of anise is a very useful remedy, or we may give tincture of hyocyamus with oil of anise. When it is deemed proper to exhibit emetics during the fit, a few spoonfuls of a solution of sulphate of zinc may be given in quick succession, as operating speedily and safely; or ipecacuanha may be employed, and the fauces tickled with a feather, to hasten its operation.

If the face be flushed, or the arteries of the neck beat strongly, it will next be proper to apply a leech to the forehead, and avoid stimulants; but if the face be pale, a few drops of the aromatic spirit of ammonia may be given repeatedly, or a little white-wine whey may be used in place of it. Opium is hurtful when the face is flushed; and even when it is pale, is only useful when there seems to be considerable irritation about the bowels, or from the gums. Oil of rue is strongly recommended by Dr Underwood; and when the fits are repeated, it will be proper to make use of this, or asafœtida, castor, or other antispasmodics. The spine should, in such cases, be repeatedly rubbed with some stimulant embrocation, or oil of amber, and a blister should be applied to the head, after it has been bathed for a time with cold vinegar.

Trismus nascentium is not a very frequent complaint in this country, but is not uncommon in warm climates. It makes its attack within the first fortnight of life, very rarely before the sixth day, and has been supposed by some to be connected with a costive state of the bowels, by others with the falling of the navel string and the state of the umbilicus\*. In some instances, the spasm is confined to the jaw, which is rigid and closed; in others it extends to the neck or trunk, which is stiff and bent back. The disease is very fatal, notwithstanding that the warm and cold bath, opiates, purgatives, and blisters, have been fully tried. The state of the navel should be attended to, and proper dressings applied, so as to avoid irritation.

\* Vide a Paper by Dr Bartram, in Trans. of Coll. of Phys. at Philadelphia. Vol. I. p. 227.

After the period of infancy is past, and during the time when the second set of teeth are coming out, convulsions are generally of the epileptic kind, attack suddenly, the patient screaming out as if terrified, and then he falls down convulsed. When the fit goes off, the patient becomes nearly quite well. These do not indicate that the patient shall be subject, after puberty, to epilepsy. They are relieved by attending to the state of the gums, removing decayed teeth, and cutting the gum over the grinder which is coming out, but especially by keeping the bowels open. Ol. succini, valerian, sea-bathing, and tonic medicines have also been found of service; asafoetida or camphor given by the mouth, or in clysters, have been useful. Convulsions have sometimes been caused by impure air, and can only, in such cases, be relieved by a removal to a purer atmosphere. This is a fact which it may be of service to remember.

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## CHAP. VII.

### *Of Chorea.*

THE convulsions called chorea sancti viti, attack children most frequently from the age of eight years to that of puberty. This disease makes its approach with languor, and dislike to the entertainments of the age; a variable and sometimes very keen appetite, in general continued costiveness, attended usually with a hardness and swelling of the abdomen, especially at the lower part, though occasionally the belly is flabby, and rather small, instead of tumid. Sometimes the bowels are open, but the stools are not of natural appearance. Presently convulsive twitches and motions of the muscles of the face take place, and are succeeded by more marked convulsive affections of the muscles of the extremities and trunk, so that the patient cannot sit still, nor carry a cup of tea safely to the mouth. These are often almost constant; even when the patient is asleep, the limbs are in motion, and the rest is greatly disturbed. He does not walk steadily, and sometimes seems to be palsied, or the motion may be very rapid, the head shaking like a rattle. The



patient is sensible during the convulsive motion. At a more advanced period, the countenance becomes vacant, the eyes dull, the speech is affected, and, in some cases, the patient cannot even swallow without difficulty. Emaciation takes place, and a febrile state may be induced.

A variety of remedies have been tried in this disease, but none with so much advantage as purgative medicines which have been prescribed with the happiest effect by Camper\*, Sydenham, and Hamilton. These, if given early, and before the disease is fully formed, will very effectually relieve the patient, and at this time they only require to be gentle, and repeated, as the state of the bowels may require. But when the disease is confirmed, "powerful purgatives must," as Dr Hamilton observes, "be given in successive doses, in such a manner that the latter doses may support the effect of the former, till the movement and expulsion of the accumulated matter are effected, when symptoms of returning health appear." Calomel and jalap are useful purgatives in this disease, and Dr Hamilton is in the habit of using aloetic pills on the days when these are not employed, which is a useful practice when the patient can swallow pills. My own experience leads me decidedly to agree with Dr Hamilton in the employment of the aloetic pills, two of which may be given three times a-day, or according to the effect they produce. Dr Underwood recommends aloetic and mercurial purges. By these means, chorea is often cured in a fortnight, or, in obstinate cases, within two months. Boys are said to be more readily cured than girls. If no great amendment take place soon, we must not on that account desist, but continue the purging plan for several weeks, and

\* "Having described the nerves, I now come to the symptoms, which are easily explained by their connection. I will begin with tremor of the feet, which is common in hysterical cases. But I ought in the first place to mention, that the dreadful hysterical symptoms, which we daily see either in individual parts, or in the whole body, are altogether dependent upon the accumulation of acrid matter in the primæ viæ; for the intollerable fœtor, the scantiness and unnatural appearance of the fœces always warn us of an approaching paroxysm of rigors and convulsions.

"Ought not purgative medicines, and even the most drastic ones, to be exhibited? they probably might cure spurious epilepsy, chorea sancti viti, and other spasmodic diseases, hitherto generally deemed hopeless by medical men."

generally we succeed at last. Tonic medicines are useful adjuvants. The food should be light and nourishing, and due exercise taken in the open air.

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## CHAP. VIII.

### *Of Croup.*

THE croup is divided by some writers into two species, the inflammatory and spasmodic ; but there is perhaps no case of croup in which spasm is not to a certain degree combined, only in some cases the inflammatory symptoms are more prominent than in others. The croup begins with shivering and other symptoms of fever, which, when the child is old enough, can be very well described by him ; but in infancy, we discover them by thirst, restlessness, starting, hot skin, and a tendency to vomit. Along with these symptoms, but sometimes for a day or two preceding them, the child has a dry hoarse cough. In some cases, the attack is very sudden, the previous indisposition being short and scarcely observable. The local disease manifests itself by a difficulty of breathing, attended with a wheezing noise ; the voice is shrill, the cough is of a very particular sound, somewhat resembling the barking of a little dog ; others describe it as resembling a cough sounding through a trumpet. It is not uncommon for vomiting to attend this cough in the early stage. The pulse from the first is frequent, the patient is restless and anxious, and the face flushed, the eyes often watery and inflamed, and the mouth frequently filled with viscid saliva or phlegm. Very soon, especially in those cases where the face is much flushed, a great degree of drowsiness comes on, from which the child, however, is frequently aroused by the cough, and fits of suffocation, and great agitation ; for this disease has exacerbations, during which the heavy sonorous breathing is exchanged for a violent struggle, during which the child makes a crowing noise, and if old enough, starts up, and clings instantly to the nearest object, and stares most pitcously. If this disease be more mild, the

face in the remission is sometimes pale, otherwise it is flushed, and before death it assumes a blue or purple colour, whilst the lips become livid; in the early stage they may be rather pale. If it do not prove suddenly fatal, the face and lips become tumid in the progress of the disease. Convulsions sometimes succeed the cough.

The duration of the complaint is various; in some cases it proves fatal in a few hours, in others not for a week, but most frequently in a day or two. Much depends, in this respect, on the degree of inflammation, the violence of the spasm, and the strength and constitution of the child. Sometimes there is much more of spasm than inflammation in the disease, in which case we have less fever, less permanent dyspnoea, and less frequent cough, but the attacks of suffocation are not milder. Those cases end best, where the breathing is least sonorous, the fever most moderate, the cough early attended with expectoration, and the symptoms seem at times to become so slight as to constitute intermission.

Dissection has always discovered, on the inside of the larynx, a lymphatic incrustation, or layer of membranous looking substance, which is sometimes coughed up in considerable portions. This, though it adds greatly to the danger and distress of the patient, is not to be considered as the cause of the disease; for it is merely an effect of inflammation, which, together with spasm, could produce all the symptoms without its aid.

The most frequent cause is the application of cold and damp. Infants under six months are not often seized with this complaint, but from that period to the age of puberty are obnoxious to it. They are peculiarly liable to it soon after being weaned.

From the nature of the disease, blood-letting has been with most practitioners a favourite remedy, and, doubtless, has of itself cured the complaint. In such cases, however, it has generally been pushed far, and been succeeded by great debility, for children do not bear much evacuation of blood. In the commencement of the disease, detracting blood, especially if followed up by an emetic, will usually be



found of great service; but it ought not to be trusted to alone, neither should it be employed late in the course of the disease, nor even at an early period ought it to be repeated, if the symptoms do not speedily seem to yield to it; neither is it generally proper in any stage, if the infant be very young. If possible, the blood should be taken by opening a vein; but if this cannot be done, leeches must be applied to the throat, but they are not equal to venesection.

Emetics have been greatly recommended by some, whilst others have little faith in their utility. I have sometimes observed great benefit from them, if employed very early; and would advise them to be given in every instance. Even in the advanced stage of the disease, emetics do much service, appearing mechanically to remove the lymphatic membrane. Decoction of seneka, and preparations of squills, have been used to assist the expectoration of the membrane, but they do not equal emetics for this purpose.

Antispasmodics have been trusted to, almost exclusively, by many; but I apprehend that their exhibition ought to be confined to a different disease, which I shall immediately notice.

Blisters applied to the throat are useful remedies, and should not be neglected. The warm bath is also of service.

Calomel would appear to be a most powerful remedy in this disease, and, if given early, it will most frequently save the child. I do not, however, recommend it to the exclusion of other remedies, with which it is by no means incompatible. The early detraction of the blood, followed by an emetic, and the subsequent use of calomel, will afford the greatest hope of removing the disease. But I think it my duty to state, that in some cases no alleviation was obtained by any remedy but the calomel; and in others it was trusted to alone, and with success. To an infant of six months, a grain and a half of calomel may be given every hour, until it purge freely; to a child a year old, two grains; and to one of two years, sometimes even four grains are given every hour, until the bowels are acted on, and the child purges freely or vomits repeatedly. The stools are generally green in colour, and their discharge is usually accompanied with an

alleviation of the symptoms. When this is observed, the dose must be repeated less frequently, perhaps only once in two hours for some time, then still seldomer, and finally abandoned. Should the child be greatly weakened, either by the disease or the medicine, the strength must be afterwards carefully supported by nourishment and cordials. It is astonishing how great a quantity of calomel is sometimes taken in a short time, without affecting the bowels, or purging violently afterwards. Occasionally above 100, and often 50 or 60 grains, are given in this disease. Salivation is not produced in children.

That excellent and experienced practitioner, Dr James Hamilton, jun. to whom we are chiefly indebted for the introduction of the use of calomel in croup in this country, from the practice of Dr Rush, is extremely unwilling to bleed children freely in their diseases, from its subsequent debilitating effects; and in croup, begins at once with the calomel, after having used the warm bath. He observes that "in every case where it was employed previous to the occurrence of lividness of the lips and other mortal symptoms, (amounting now to above forty) it has completely succeeded, both in curing the disease, and in preventing any shock to the child's constitution." He adds, that he has now seen two cases, where, although the croup was cured, the patient sunk from weakness; and therefore very properly gives a caution to stop the calomel, whenever the symptoms begin to yield. The alleviation in true croup follows the discharge of dark green stools, like boiled spinage; in spasmodic croup, it takes place whenever vomiting has occurred. When much debility is produced, he, besides using cordials, applies a blister to the breast. I have a high opinion of the efficacy of calomel, but I cannot speak by any means so strongly as Dr Hamilton; for even when it was early, pointedly, and exclusively employed, and brought away green stools, I have known it fail; and deem it my duty most earnestly to caution the reader against trusting to it exclusively; at the same time I must add, that I have it known procure recovery from very desperate cases, even without evacuation by stool; and

when, after a great quantity of calomel was given and relief obtained, it was necessary to open the bowels by clysters. Calomel has been combined with ipecacuanha to produce vomiting, but I cannot satisfy myself that I have ever seen this combination do more good than either of the medicines would have done singly.

Spasmodic croup, or acute asthma, is often, but not necessarily connected with inflammatory croup. There is, perhaps, no case of the latter disease which is not attended with spasm of the muscles of the larynx, but there are many cases of spasm without inflammation; yet if the spasm continue long, there is a great risk of inflammation taking place, and of a membrane being formed. The spasmodic croup attacks children chiefly, but it may also affect women, especially about the age of puberty, and harass them occasionally for many years afterwards. It makes its attack very suddenly, generally at night, and sometimes for many nights in succession, especially if the child be agitated, or the mind of the young woman anxious respecting it. The patient breathes with difficulty, and with a wheezing sound, has a hard barking cough, with paroxysms of suffocation, as an inflammatory croup. The extremities become cold, the pulse during the struggle is frequent, but in the remission it is slower; and if the remission be great, it becomes natural, unless kept up by agitation. There is little or no viscid phlegm in the mouth, no drowsiness, but rather terror, and the eye stares wildly during the paroxysm. The disease is often suddenly relieved by sneezing, vomiting, or eructation. It differs, then, from the inflammatory croup, in the suddenness of its attack, in there being little fever, but only quickness of pulse, greatly abating when the child does not struggle for breath; no drowsiness, and little phlegm about the mouth. The cough is less shrill, and the fit often goes off suddenly and completely, either spontaneously, or by the use of the remedies acting quickly. Sometimes, however, inflammation takes place, and this disease is, in infants, very readily converted into true croup.

It is at times brought on by exposure to cold, and in that



case, it is occasionally preceded by slight sore throat, or hoarse cough; but oftener the spasm comes on without any precursory symptoms. Sometimes it is excited by dentition, or, if the patient be older, by passions of the mind. Not unfrequently, a renewal of the disease is excited in those who are subject to it, by eating a full meal in the evening.

With regard to the treatment, I shall briefly state the result of my observation. In young girls, venesection has uniformly given relief, the spasm suddenly abating, and very soon going entirely off, after a certain quantity of blood has flowed. Topical blood-letting has not the same effect. But if the paroxysm should be repeated for many nights, this remedy cannot be employed on every attack, as it debilitates and predisposes to the disease. Emetics, such as sulphate of zinc, have the same effect with blood-letting in general; but sometimes the fit, though impeded during their operation, returns, and in such cases has yielded to venesection. Occasionally the emetic has been very long of operating, the stomach not being easily acted on; and in those cases, blood-letting has produced speedy vomiting and immediate relief. Opiates and antispasmodics, such as ether, given in large doses, have, if exhibited in the very commencement of the attack, sometimes checked it, but have not always that effect, and, if not given soon, are longer of procuring relief. With regard to the effect of calomel in croup affecting girls and women, I can say nothing; for the paroxysm is so severe, that we cannot and must not trust alone to its operation.

A relapse is to be prevented by giving purgatives, and avoiding exposure to cold damp air. In young girls, a course of tonic medicines alone, or combined with *asafoetida* or *valerian*, will be useful; and when the attacks have been kept off for some time, sea-bathing will be proper.

With infants we generally succeed by giving instantly an emetic, and afterwards calomel in considerable doses, so as to produce sickness and vomiting, or free purging. But if the emetic do not decidedly mitigate the disease, then, in place of trusting solely to the calomel, we premise if possible venesection. A-

asafoetida\* has been strongly recommended in this disease, and has sometimes a very good effect. The warm bath is also useful. If the child be about the period of dentition, the gum should be examined, and cut if tumid. If the disease do not soon yield to these remedies, there is ground to suppose that it will be converted into the other species of croup; but this affects the prognosis rather than the treatment.

Some children are subject to slight wheezing, continuing for a day or two, with intermissions, and accompanied with a hoarse cough, but without fever. Emetics, laxatives, and a large burgundy pitch plaster, applied to the back, remove the disease.

Infants during dentition are subject to sudden attacks of spasm about the wind pipe, producing a temporary feeling of suffocation with a crowing sound, but there is no hoarse cough. It is apt to take place suddenly at night, or when crying. It is relieved by rubbing the throat well with anodyne balsam, or laudanum, and giving a combination of tincture of asafoetida, and of hyocyamus. The warm bath is also useful. The gum should be cut.

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## CHAP. IX.

### *Of Hooping-Cough.*

THE hooping-cough often begins like a common cold, the child coughing frequently, and having more or less fever. In some cases the fever is slight, going off in the course of a week, in others very severe and long continued, attended with great oppression or sickness, and want of appetite. The cough generally comes on very abruptly, and is sometimes early attended with that sonorous spasmodic inspiration, denominated hooping, in other cases, not for a considerable time, and this is

\* Dr Millar has given an ounce of this gum to a child of eighteen months old in forty-eight hours, and almost as much at the same time in form of elyther. His formula is as follows: R. G. asafoetida, ʒii. Spt. mindereri, ʒi. Aq. pulg. ʒiii M s. a. A table-spoonful of this is to be given every half hour. Vide Observations on Asthma, p. 43. This medicine is also prepared as a nostrum under the name of Dalby's Carminative, which has been used for children.

considered as a favourable circumstance, but it is not always so, for in young children, death may take place, although the disease never fully forms. The fits are generally most frequent, and most severe during the night. When the cough becomes formed, the paroxysm consists of a number of short expirations, closely following each other, so as produce a feeling of suffocation, relieved at last for an instant by a violent, full, and crowing inspiration; then in general the cough or spasmodic expirations recommence, and the paroxysm, consisting of these two parts, continues until a quantity of phlegm is coughed up or vomited, alone, or with the contents of the stomach, and this ends the attack. The expirations sound like a common cough, but are more rapid, and frequently repeated as in violent laughing. Sometimes the sound is lower, or the cough resembles the chattering of a monkey, quickly repeated. These paroxysms vary in frequency and duration. Sometimes they are slight; at other times, and especially during the night, they are attended with a most painful sensation, and appearance of suffocation, the face becoming turgid and purple, the sweat breaking, and blood gushing from the nose or other parts. The extremities become cold during the fit, and the whole frame is much agitated. But even severe as the paroxysms are, if the disease be not attended with fever, the patient seems quite well after the fit, and begins to eat with a renewed appetite. A fit of crying will be at times, even after the disease has been apparently removed, excite the cough. The features often remain swelled for a considerable time.

Hooping-cough is very dangerous for infants, as they often die suddenly in a fit of suffocation; elder children escape more safely, though even they are sometimes carried off, the fever continuing, or anasæra coming on, with exhaustion. Sometimes the lungs become diseased, and hectic fever takes place, or peripneumony is produced, or the lungs become œdematous. Convulsions may also occur and carry off the child.

Many remedies have been employed in this disease, which it will be proper to divide into those intended to abate the



fever, and those given to relieve the cough. Venesection has for the first of these purposes been recommended; but it is very rarely requisite, and only when the patient is plethoric, and we apprehend that some vessel may burst in the lungs from the violence of the cough, or when there are symptoms of inflammation. Leeches may in these circumstances be applied to the chest. The most generally useful remedies are laxatives and the saline julap, which often in a few days moderate the fever greatly. The tepid bath is useful, and, if there be much irritation and restlessness, hyocyamus sometimes does good.

For the relief of the cough, nothing is so beneficial as emetics. These have been given in nauseating doses, so as to make vomiting be readily excited by the cough; but, in general, a full dose of ipecacuanha will be as effectual, and is less distressing. At first, the emetic should be frequently repeated, especially to infants, perhaps once a-day, or once in two days, according to circumstances; and this degree of frequency is by no means injurious. Antimony has been highly praised by many, but it is more apt to weaken the stomach, and in very young children it sometimes produces violent effects. Stimulating substances, such as a combination of soap, camphor, and oil of turpentine; or juice of garlic, or oil of amber, or of thyme, &c. rubbed over the spine, or the thorax and the stomach, have a good effect; and similar applications to the soles of the feet have certainly in some cases done much good. Antispasmodics, such as asafoetida, ol. succini, musk, &c. have been recommended, and in some cases are successful. Opiates are also of service. Dr Willan says, that he found the watery infusion of opium more useful than any other narcotic. When the disease is protracted, cicuta has been recommended, but it does not seem to have any advantage over opium, or hyocyamus. It has also been applied externally. The most effectual remedy, however, is change of air, which often has a marked effect on the disease in a few hours. When the patient becomes restless, and coughs more, it should again be changed. The diet ought to be light. If there be fixed pain in

the chest, difficulty of breathing, and fever indicating inflammation, either venesection or leeches, according to the age and circumstances of the child will be necessary; but our evacuation must be prudently conducted. Blisters, and digitalis in such cases are useful. Pain produced merely by the violence of the cough, remitting or going at times entirely off, and generally seated about the upper part of the sternum, is relieved by those means which relieve the cough.

When the paroxysms have been very severe, the breathing oppressed, the cheeks livid, and the pulse very weak, some children have been saved by the application of leeches to the chest, blisters, and small doses of the compound powder of ipecacuanha.

When the patient is threatened with hectic, or becomes emaciated and weak, nothing is of so much benefit as country air and milk diet, at the same time that we keep the bowels open. Blisters should be applied to the breast, if there be fixed pain or dyspnœa. If there be anasarcaous swelling, the digitalis, conjoined with cordials, will be useful.

Convulsions sometimes are excited by the fits, or occur at the same time with them, and immediately suspend the cough. They are very alarming, and may suddenly carry off the infant, especially if it be very young. The child should instantly be put into the warm bath, which is to be repeated as often as the convulsions come on. The bowels should be opened, the head shaved and blistered. If the fits be repeated, and if the child be plethoric, leeches ought to be applied to the temple. The air ought also to be, if possible, immediately changed. In some cases; tincture of hyocyamus given in a mixture, or clysters containing camphor, seem to allay the tendency to spasm; and in every instance, it is proper to rub the back and belly with anodyne balsam.

If the cough return after it has gone off for a time, a gentle emetic is the best remedy. A sudden change of weather from warm to cold, is very apt to renew the cough. If the face or lips remain swelled, gentle laxatives are proper.

During the continuance of the disease, the diet must be light, but nourishing, if the patient be weak; but more spar-

ing at first if he be on the other hand plethoric, and inclined to inflammation. Toward the conclusion of the disease, bark and tonics are useful to re-establish the health.

There is a cough very like whooping-cough, and which gives rise sometimes to the groundless fear that the child is going to take that disease; or on the other hand, if somewhat prolonged, it may pass for whooping-cough; and afterwards, the child being exposed to infection, takes the disease, and is said to have had it twice. This kind of cough has less of the suffocating appearance than the whooping-cough; the expirations are fewer, and do not follow each other so quickly, and the inspiration is not performed so quickly, and with the distinct whooping sound. It sometimes succeeds measles, or appears as a kind of influenza. It is cured by an emetic and anodynes.

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## CHAP. X.

### *Of Catarrh.*

INFANTS are subject, as in after life, to catarrh, either common or epidemic. It is attended with fever and inquietude, redness of the cheeks, watery discharge from the eyes and nostrils, disposition to sleep, frequent, and sometimes irregular pulse, panting and shortness of breathing, with frequent cough, which, however, is not severe. It generally goes off within a week, by the use of gentle purges, blisters, antimonials, and, if the fever be considerable, leeches applied to the breast. A hoarse barking cough, is cured by an emetic, and wearing flannel round the throat.

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## CHAP. XI.

### *Of Bronchitis, Inflammation of the Pleura and of the Stomach.*

BRONCHITIS is far from being an uncommon disease of infants. It sometimes takes place very early after birth; in other instances not for several weeks. It begins with cough and pretty copious secretion of mucus or phlegm, which, however, the child will not allow to come out of the mouth, but



swallows. The cough is frequent, but not uniformly so; coming on in paroxysms. It is of stifled sound, and somewhat hoarse, or occasionally even shrill, from slight inflammation at the top of the windpipe. The breathing is oppressed or sonorous, but not permanently so. Vomiting is also not an uncommon attendant, and the stools are generally green and offensive: The child takes the breast pretty freely, but dislikes all meat. Presently the secretion becomes more of a purulent appearance. The respiration is more oppressed, and the noisy breathing is more frequent. The hands, but especially the feet, swell a little, whilst the body becomes emaciated. The cheeks are occasionally flushed in the evening, and the pulse, which was always frequent, becomes still more so, and irregular. The fits of coughing are severe, and attended with appearance of suffocation, and at last the child dies. On opening the body we find the ramifications of the trachea filled with purulent looking matter, and in some parts there is an approach towards the formation of tubercles. The lungs are sometimes paler than usual, in other instances more solid.

This is a very obstinate disease, but it does not prove very rapidly fatal. In the commencement it resembles common catarrh, and requires the same treatment. At different stages, and under various circumstances, I have tried emetics, blisters, calomel, and expectorants, but without decided benefit. Blisters, with calomel, combined with ipecacuanha, to act both on the bowels, and also as an expectorant; together with a removal to the country, appear to constitute the best practice.

Inflammation of the pleura is more frequent with children than many suppose. The skin is very hot, the face flushed, the pulse quick, the breathing short and oppressed; there is a cough, aggravated by crying, by motion, and by laying the child down in bed. He is likewise more disposed to cough, and is more uneasy on the one side than the other. If not relieved soon, the breathing becomes laborious, the extremities cold, the cough stifling, with rattling in the throat and stupor; or the pulse becomes irregular and intermittent, the extremities swell, the countenance is sallow or dark coloured,

the breathing difficult, with short cough, and frothy expectoration, which oozes from the mouth. On inspecting the chest, the inflammation is sometimes found to have terminated in hydrothorax, oftener in adhesions. This disease requires venesection, or the early application of one or more leeches to the sternum, according to the age and constitution of the child; the use of blisters, calomel, purges, and the tepid bath. Antimonials and digitalis are also sometimes of service. In the last stage, diuretics are proper, especially a combination of squills and digitalis, whilst the strength is to be supported by the breast-milk, or light diet.

This disease sometimes terminates in abscess and purulent spitting, with hectic; but much more frequently, the pulmonary consumption of infants and children begins, as in adults, more slowly, is marked by a short dry cough, flushings of the face, frequent small pulse, difficult breathing, wasting, and nocturnal sweats. The expectoration is generally swallowed, but sometimes it is ejected, or it is vomited up, and is found to be purulent. There is seldom any cure for this state; all that can be done is to send the child to the country, apply small blisters to the breast, keep the bowels in a proper state, give a mixture containing opium and digitalis, and support the strength with suitable nourishment. If the expectoration be only phlegm, then, although all the other symptoms be present, there is considerable hope of saving the child. But if it be purulent, and the parents are consumptive, the danger is much greater. This state, however, does not in general succeed pleurisy. It is generally induced more slowly, by tubercles, accompanied with enlargement of the bronchial glands\*.

Inflammation of the stomach is not a common disease of infancy, nor is it discovered without considerable attention. There is great fever, frequent vomiting, the mildest fluid being rejected soon after it is swallowed, the throat is first

\* Although it is not exactly connected with my present subject, I may mention, that sometimes the bronchial cells are much enlarged, the child has cough and difficult breathing. The air escapes, and passes from the root of the lungs to the mediastinum, insinuating itself betwixt its layers, and thence to the neck, where it produces emphysema. Punctures ought immediately to be made.

inflamed, and then covered with aphthæ, which spread to the mouth. The child cries much. The region of the stomach is full and very tender to the touch. The bowels are generally loose. If the child be old enough to describe his sensations, he complains of heat or burning about the stomach and throat; if younger, he directs the hand frequently to the stomach and breast. There is sometimes, from the first, a cough and short breathing, but the constant vomiting shews the disease to be in the stomach. It is not easy to say what causes this, for it cannot always be traced to acrid or stimulating substances swallowed. It is proper immediately to apply one or more leeches to the pit of the stomach, according to the age and strength of the child; then a blister is to be applied, and stools are to be procured by calomel. Fomentations and the warm bath are also useful. M. Saillant recommends the juice of lettuce, to be given in spoonfuls every hour, but I do not know any advantage this can have over mucilage and laxatives. The disease is uncommon, but when it does occur, is apt to be mistaken for a disordered state of the stomach and bowels, producing aphthæ.

There is another state of the stomach, which, from the softness of the texture, is apt, after death, to be confounded with gangrene. There are, however, no marks of inflammation; but the stomach seems as if it had become so soft by maceration, that it gives way on being handled. This state is sometimes confined to one part of the stomach \*, sometimes it extends even to the small intestines, and more than one child in the same family have died of this disease. It is not easily discovered before death, for its most prominent symptoms, namely, purging, with griping pains, occur in other diseases of the bowels. It is, however, very early attended with coldness of the face and extremities, and the countenance is shrunk and anxious. It affects the intestines oftener than the stomach. This state of the stomach cannot always be attributed to the effect of the gastric juice. When

\* Dr Armstrong mentions a case of this kind, where the upper part of the stomach was thus diseased, but the pylorus sound. The stomach was distended with food, but the intestines were very empty, which might be owing to diminished power of contraction in the stomach.



the stomach is acted on by this solvent after death, we find that it is very soft, some of it in a state of semi-solution, the inner surface being dissolved, and some of it actually removed, so as to make a hole. When the preparation is put into spirits, and held between the eye and the light, the flocculent appearance of the inner surface is distinct, and numerous globules are seen within the peritoneal coat, which are probably the glands undissolved.

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## CHAP. XII.

### *Of Vomiting.*

VOMITING is very seldom an idiopathic disease of children. Many puke their milk after sucking freely, especially if shaken or dandled. This is not to be counted a disease, for all children vomit more or less under these circumstances. A fit of frequent and repeated vomiting, soon after sucking or drinking, if unattended with other symptoms, and the egesta are of natural appearance, may be supposed to depend on irritability of the stomach, which can be cured, by applying to the stomach a cloth dipped in spirits, and slightly dusted with pepper, or an anodyne plaster. Sometimes a spoonful or two of white-wine-whey settles the stomach. If, however, the egesta be sour or ill-smelled, and the milk very firmly curdled like cheese, and the child is sick, it is probable that more of that caseous substance remains, and a gentle puke of ipecacuanha will give relief. On the other hand, should the egesta be green and bilious, gentle doses of calomel will be serviceable, especially after an emetic. The sickness which sometimes precedes vomiting, especially if it be caused by bile, is accompanied with great oppression, panting, deadly paleness, and an appearance altogether as if the child were going to expire. The relief given in this state, by vomiting, is great and sudden.

Vomiting, connected with purging or febrile disease, is to be considered merely as symptomatic. It is, however, desirable to restrain it, which is done by giving small doses of saline julap, and removing the primary disease. Sometimes

the œsophagus is found ruptured in children, and the contents of the stomach poured into the thorax. This probably happens from spasm taking place at the upper part of the œsophagus, whilst the stomach is rejecting its contents.

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## CHAP. XIII.

### *Of Diarrhœa.*

WHEN we consider the great extent of intestinal surface, its delicacy, and the intimate connection which exists betwixt the bowels and other organs, we shall not be surprised at the powerful and important effects produced on the system at large, by disorder of the alimentary canal.

In attending to diarrhœa, we must examine the structure of the intestine, and the purposes it is destined to perform. The bowel itself consists of muscular fibres, of glandular apparatus, of nerves and blood-vessels, and of a system of lacteal vessels, which probably do more than absorb, assisting also, by glandular action, in the formation of chyle, which does not perhaps exist in a perfect state in the contents of the bowels. Now, although these different parts tend to constitute one organ, yet they are not so blended in action, that all must be alike affected when the organ is deranged. All may be disordered, but one sooner, and to a greater degree, than the rest. The fibres may be excited to inordinate action, producing rapid contraction, and speedy expulsion of the contents; and this may, or may not be accompanied with spasms and great pain. The exhalents may be greatly affected, producing copious discharge of intestinal secretion, which may be watery, mucous, slimy, or, when the vessels are abraded or open, tinged with blood. The absorbents may have their action impeded, and the chyle is not duly absorbed. The injury of one of these systems of organization not only affects the rest, but this intestinal disease influences parts immediately connected with the intestines, such as the stomach, liver, pancreas, &c. This leads us to consider the contents of the bowels. If the food be good, and the stomach digest properly, the chyme is good and natural. But if the

food be bad, or in exuberant quantity, or the power of the stomach be impaired, the chyme is not properly formed, and the food is found in the intestines not thoroughly changed or digested; perhaps little altered in its appearance. If the bowels have the same torpor with the stomach, it is retained, and forms accumulations, ending in great mischief. If the bowels be irritable, as in diarrhœa, it is generally passed speedily. The egesta from the stomach are naturally mixed with the bile, pancreatic juice, and intestinal secretion; and the colour of the compound is yellow, or yellow with a brown tinge; and during its passage downwards, a certain quantity of gas, possessing a peculiar smell, is extricated \*. In young infants, however, when they are properly suckled, the stools are somewhat different from their state at a more advanced period. They are of a yellow colour, are something like custard, or are curdy, and have by no means the offensive smell they afterwards possess. If the stools have a very curdy appearance, or are too liquid, or green or dark coloured, or ill smelled, they are unnatural. The changes effected in the passage of the chyme are not merely chemical, but dependant on animal action; for the contents of the stomach, mixed with the fluids found in the intestines, and exposed to the same degree of heat, will not form natural looking fæces, but the substances will simply assume the acetous or putrefactive fermentation. If the powers of the stomach and intestines be impaired, then this fermentation goes on to a great degree in the stomach and bowels, much gas is extricated †, inflation is produced, and the aliment becomes sour or putrid. If too much bile be added, the fæces are green, sometimes dark-coloured. This redundancy of bile may be produced by causes acting immediately on the liver, at least not through the interposition of the intestines, and the bile

\* Both the smell and the colour of the fæces are found to depend greatly on the bile. When the bile is obstructed, the stools are clay coloured or pale, and have not the feculent smell.

† Vauquelin has ascertained, that the stools are always more or less acid. When exposed to the air, they become more acid, and soon afterwards exhale ammonia, which they do till destroyed. The greatest part of the gas extricated in the bowels, consists of carbonic acid, with carbonated and sulphurated hydrogen, more or less fetid. In indigestion, the greatest part of the gas is inflammable. Fourcroy System, &c. Tom. X. p. 75.



comes then to be a source of irritation to the bowels, and excites diarrhœa; or the affection of the bowels may influence the liver, and excite it to a greater secretion. Some children are more bilious than others, and are subject to fits of paleness, sickness, and bilious vomiting. The pancreatic juice and intestinal secretion, when not changed in quality, but only increased in quantity, are probably not, like the bile, a source of irritation, but only the produce of it. But these discharges, sometimes mixed with bile, sometimes with blood effused from a small vessel, may accumulate, together with the egesta of the stomach, and form a black, pitchy looking substance\*, which sooner or later produces very bad effects. In other instances, these form a more watery substance, which is passed off with griping, and purging of stools like moss water.

The colour of stools in diarrhœa varies according to the violence of the disease. In slight cases, where the action of the bowels is only increased in degree, but not altered in kind, and the stomach is not injured, the fæces are of a yellow colour, but thin, owing to the increased discharge, and have not run into fermentation. When in children the digestive faculty is somewhat impaired, and the aliment is improper, fermentation goes on more strongly, and the fæces contain more acid than usual, which, although the bile be not increased in quantity, may give them a green colour†, and the intestines are distended with air. Very green stools, however, imply a redundancy of bile, and the darker the shade of green the greater is the quantity of bile. When the irritation is great and universal, the stools are very watery, and of a dark green colour; or if the irritation be still greater, they are brown; and in either case, if the child be on the breast, portions of coagulated milk are found

\* The decomposition of bile by acids, which combine with its soda, furnishes a precipitate, which is thick, viscid, very bitter, and inflammable. This is probably the origin of pitchy looking stools in some cases, though in others they may proceed from effused blood.

† All acids decompose bile, and in general produce a green precipitate. Either an unusual quantity of bile, or of acid in the bowels of children, will produce green stools; and stools which are not at first green, often become so in a short time after they are passed.

swimming in the fluid; if not, we have either bits of any solid food taken by the child, or small masses of dark-coloured fæces which had been accumulated in the bowels. When the digestive faculty is almost gone, the stools consist of the aliment mixed with bile. Thus, if the child be drinking milk and water, or be not weaned, the stools consist of green, watery fluid, with clots of milk, streaked with bile. When the irritation is greatest at some particular part of the intestines, it is not unusual for these appearances to alternate with discharge of slime and blood, as we see in intus-susception. When the secretion of bile is diminished, the stools have a cineritious appearance; but this state is not often met with in diarrhœa. Sometimes, when the liver is affected, or the bowels much diseased, the fæces, may, among other changes, put on the appearance of pale yolk of egg, or are almost like pus.

Diarrhœa may be injurious in different ways. The increased peristaltic motion of so great a tract of sensible muscular substance, must, like other great muscular exertion, weaken the bowels, and thus the whole body which sympathizes with it. Great debility is often rapidly excited by affections of the intestinal fibres, though there has been little évacuation. Diarrhœa likewise injures the system, by the irritation and great secretion which often accompanies it; add to this the diminution of the powers of digestion, and the obstacle afforded to the absorption of the due quantity of chyle, together with the derangement which other parts of the system may suffer, and the diseases thus excited, such as convulsions, anasarca, &c.

On inspecting the bowels after death, they are very seldom found in a state of inflammation, but either greatly inflated and relaxed, or with more or fewer intus-suscepted portions. In one case, no fewer than 47 intro-susceptions were found in the same body. On examining these portions, the valvulae conniventes are found to be rather more prominent than usual, but the parts are not inflamed. Invagination of the intestine is the most frequent cause of fatal diarrhœa, not less than 50 cases having occurred to my bro-

ther in the course of his dissections. Intus-susceptio may be produced suddenly, in consequence of spasm, and may occasion great pain, with purging; or it may be caused by acrid purgatives, or those which produce much griping, as senna tea, made by boiling the leaves; or it may take place in diarrhœa, when attended with considerable irritation, and it adds to the violence of the disease. It is sometimes accompanied with a diseased state of the glands. In this case there may be a swelling of the external glands, and there is often a tendency to cough. There may be a double intus-susception, and the tumor so formed may lodge in the pelvis, and fill it. Inflammation is very far from being a necessary attendant on this state, it is even uncommon.

The diagnostic of intus-susceptio is very obscure, and whatever may be said to the contrary, I believe we have no certain mark by which to judge. It has been discovered, when no previous circumstances led to a supposition of its existence. But in general there is considerable pain, and marks of local irritation; such as slimy stools, with or without blood; sometimes a little frothy slime is passed, sometimes a substance like rotten eggs, and at times the contents of the intestines are vomited. It is attended with stretchings and cryings, as in colic, with occasional attacks of great paleness, like syncope; the belly is tender to the touch, and sometimes in infants the pulse is slower than ordinary. When the disease continues long, the emaciation is very great, the face resembling the bones, with merely a skin covering them, whilst the eyes are sunk. On the extremities, the skin is lax, and seems much too wide for the bone and muscles. Sometimes the intus-suscepted portion is thrown off, and passes by the rectum.

Dissection likewise shews, that a diseased state of the liver not unfrequently accompanies diarrhœa, and this may be a cause of purging oftener than is supposed. It is to be suspected, when the biliary secretion is most affected and the region of the liver is fuller than usual, when there is cough, frequent fits of sickness, and vomiting or purging of



bile. It is most effectually remedied by small doses of calomel.

In some cases, the intestines become very soft, white, or almost diaphanous, and easily torn, and contain a substance somewhat like purulent matter, or thin custard.

Diarrhœa appears under various circumstances, not only with regard to the nature of the stools, but their frequency, the pain which attends them, the duration of the complaint, and the effect on other parts. In some cases the stools are extremely frequent, and uniformly so. In others, the dejections come in paroxysms, being worse either through the night or through the day. Some children are greatly griped; others are sick, oppressed, and do not cry, but moan. In severe cases, the stomach is very irritable, rejecting the food; but it is not equally so in every stage of the disease, though the stools may be the same in frequency. The appetite is more or less impaired, and in bad cases the aliment quickly passes off, and every time the child drinks it is excited to purge. The mouth, in obstinate bowel complaints, generally becomes aphthous, and the anus excoriated or tender, and it is not uncommon for the feet to swell. Sometimes the child is flushed at certain times of the day, or the face is uniformly pale, and the skin waxy in appearance. In general, if the disease be severe, a considerable degree of fever attends it, and a continued fever in this disease is always unfavourable. The stools may come away with much noise from wind, or may be passed as in health. When there is great irritation, they are either squirted out forcibly, or come in small quantity, with much pressing. Diarrhœa sometimes proves fatal in 48 hours, but it may be protracted for several weeks, as is often the case when intus susceptio has taken place. In such protracted cases, the emaciation is prodigious, the face is lank, the eyes sunk, and the expression anxious; the strength gradually sinks, the eyes become covered with a glossy crust, the extremities cold, the respiration heaving, and the child dies completely exhausted.

Diarrhœa may be excited by a variety of causes; such as

too much food, or sudden change of the kind of aliment, and hence it is often caused by weaning a delicate child. Attempts to bring up children altogether on spoon meat, some injurious quality of the nurse's milk, improper diet after weaning, the irritation of ill digested food, redundancy of bile, previous costiveness, dentition, the application of cold to the surface, or a morbid state of the bowels connected with general debility, produced either by bad air or natural delicacy of constitution, are causes of diarrhœa. Those children suffer most who are feeble, puny, or delicate.

As diarrhœa is a frequent cause of death, we cannot be too attentive to its treatment, nor too early in the use of remedies, especially as we find, that if it be neglected in its commencement, it is apt to end in a very obstinate or incurable state. On this account I have been led to consider this disease very carefully, and shall briefly mention the treatment I have found most effectual. When the stools are natural in colour, but more liquid than usual, the frequency moderate, the continuance short, and no fever is present, it will be useful to give small doses of rhubarb, conjoined with an aromatic, taking care, however, that these do not end in producing the opposite extreme, or costiveness. In many cases, the disease will subside of itself; but if it do not abate spontaneously, or by the use of small doses of rhubarb, then it comes to be considered, how far it is proper to check the inordinate action of the fibres of the intestines. This is readily done by an anodyne clyster. But if the diarrhœa have been excited by improper food, or redundancy of food, or if it be attended with acute fever, and especially if the child be plethoric, it will be useful to give some mild laxative, such as magnesia and rhubarb, or an emulsion containing castor oil, or small doses of calomel. The tepid bath is also beneficial. If there be oppression, with fever or sickness, a gentle emetic will be a proper prelude to the laxatives. Afterwards, if the disease continue, and there be marks of much irritation of the fibres, anodyne clysters will be of signal service.

If the diarrhœa come on quickly, and the stools are from the first green or morbid, and the stomach be irritable, or

its functions impaired, we should examine the gums, and cut them if the child be getting teeth. This removes or lessens a source of irritation. But whether the disease be produced by teething, by change of food consequent to weaning, or other causes, great attention is necessary. If the child be sick and oppressed, a few grains of ipecacuanha will be proper; and afterwards small doses of calomel\*, or some other laxative†, should be given morning and evening. These carry off the morbid feculent matter, and excite a better action of the bowels. The calomel is usually a most effectual remedy, and it may be given even to infants a few days old. To them a quarter or half a grain, rubbed up with sugar is a proper dose, and may be given morning and evening. To older children we give a grain. If laxatives do not increase the debility and pain, and if they render the stools more natural in appearance, they do good, and may be continued in decreasing quantity, till they are abandoned altogether. But if they merely increase the frequency of the dejections, without greatly altering their quality, the stools continuing watery, ill-coloured, and offensive, and the strength and appetite sinking, we can expect no good by continuing them, and must restrain the purging by repeated anodyne clysters, taking care that we do not delay their use too long. When the secretion is copious, and the stools frequent, and perhaps squirted out with great irritation, the strength will sink very rapidly, and a few hours may decide the fate of the child. In such circumstances, it is necessary, even although the contents of the bowels be morbid, to moderate the fibrous and secretory action, by anodyne clysters. Afterwards the morbid matter is expelled, or can be removed by gentle laxatives. Opiates given by the mouth have often a bad effect on the child, and never are equal in bene-

\* That excellent practitioner, Dr Clarke of Dublin, has strongly advised half a grain of calomel to be given every night, or every second night, to infants, when troubled with green stools and griping; observing, that in the course of a week or two, the stools become natural, and that it is rarely necessary to give more than from 4 to 5 grains altogether. Mem. of Irish Acad. Vol. VI.

† Cold drawn castor oil may be given in the following form: R. Ol. Ricini, ʒiij; Manna, ʒss; Spt. ammon. Arom. ʒi; Aq. Cassia ʒss; aq. Pont. ʒiiss fiat emulsio. Of this a tea spoonful may be given as often as necessary.



fit to clysters. Cretaceous substances, joined with aromatics, are useful when there appears to be a redundancy of acid; but astringent medicines, such as kino or catechu, though they sometimes seem in slight cases to be of service, yet in more obstinate diseases fail, unless they be combined with opium, and then the benefit is perhaps more to be ascribed to that drug than to their effect; or if given in great quantity, they may perhaps excite to invagination of the intestines. In obstinate cases, small doses of calomel given morning and evening, with the use of anodyne clysters at the same time, to keep the purging within due bounds, are of more service than any other remedies, and will save a great number of children; I can speak of this practice with confidence. Dr Armstrong, however, when the stools are liquid or watery, sometimes colourless or brownish, or streaked with blood, and of very offensive smell, advises antimonial vomits, repeated every six or eight hours, till the stools change their appearance. But this remedy operates severely, and may induce no small degree of debility. If the plan be rejected, he advises a solution of epsom salts, with a small quantity of laudanum. Dr Underwood, in this disease, prescribes emetics, then warm purges, and afterwards small doses of ipecacuanha, with absorbents and aromatics.

Dr Cheyne, in obstinate and prolonged purging, which, from frequently occurring about the time of weaning, he calls atrophica ab lactatorum, strongly advises small and repeated doses of mercury, as the most effectual remedy.

When there is much fever, the use of the tepid bath morning and evening, and small doses of saline julap, or compound powder of ipecacuanha, and clothing the child in flannel, will be of great benefit.

In every case, external applications have, I think, a claim to be employed. These consist of friction with anodyne balsam, or camphorated oil of turpentine, or the application of an anodyne plaster\*, to the whole abdomen, which is bet-

\* Such as the following: R. Saponis, ʒi; Empl. Lytharg. ʒvi; Ext. Cicuta. ʒii; Ol. menth. pip. ʒss; Fiat empl. Or R. Empl. resinos. ʒvi, Pulv. opii ʒi, Camph. ʒii; Ol. Juniper ʒss; Fiat empl. Or if there be much spasm, we may use the Empl. nusatida, Pharm. Edin. with the addition of opium.

ter. Small blisters in succession, applied to the belly are highly useful. It is also proper to bandage the belly pretty firmly, but by no means tightly, with flannel.

During the whole course of the disease, it is proper to support the strength with light nourishment, such as beef-tea, arrow-root-jelly, toasted flour boiled with milk, &c.; or if the child be not weaned, it is sometimes of service, in continued or repeated attacks of diarrhœa, to change the nurse. The strength should be supported by small quantities of white-wine whey, given frequently. If the child, as is frequently the case, will not take nourishment, then clysters of beef tea, or arrow-root are to be employed, mixed with a few drops of laudanum. These are of signal service, and ought to be early and carefully employed till the child can take food into the stomach.

When the mouth becomes aphthous, it may be washed with a little syrup, sharpened with muriatic acid; or borax may be employed, along with the proper internal remedies; and when these restore the bowels to a healthy state, the mouth becomes cleaner. The appearance and disappearance of the aphthæ generally mark the fluctuation of the bowel complaint. The excoriations which appear about the anus require to be bathed with solution of sulphate of zinc, and call for great tenderness in administering clysters.

When the feet become swelled, and the urine diminished in quantity, some diuretic must be added to the other means. The best is the spiritus ætheris nitrosi.

If the child become drowsy, or have a tendency to coma, much benefit will be derived from shaving the head, and applying a small blister to the scalp. Affections of other organs, supervening on bowel complaints, must be treated promptly on general principles.

It will thus appear, that the practice in diarrhœa is chiefly confined to the following points:

*First*, To remove every exciting cause, searifying the gums in dentition, rectifying the action of the liver when it is deranged, and regulating the diet when the quality of the food may be supposed to have disordered the bowels.

*Second,* To lessen sickness and oppression of the stomach by a gentle emetic; but particularly to remove irritating fæces, and excite a better action of the intestinal surface, by small doses of calomel in prolonged cases, or by a dose of rhubarb and magnesia in recent cases of purging. The circumstances under which the administration of laxatives is beneficial or injurious, have been already pointed out.

*Third,* To restrain inordinate peristaltic motion, and excessive secretion, by anodyne clysters and external applications, neither of which are incompatible, with the occasional use of calomel.

*Fourth,* To remove or allay coincident or consecutive symptoms by appropriate remedies.

*Fifth,* To support the strength from the first by suitable nourishment and cordials; and whenever the stomach cannot receive or retain food, to give nutritive clysters.

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## CHAP. XIV.

### *Of Costiveness.*

COSTIVENESS is natural to some children,—acquired by others. In the former case, it often happens, that the mother is of the same habit, and in these circumstances, we find that less detriment accrues than in the other; yet even here it is necessary to prevent the costiveness from increasing, as it may excite not only cholic, but more serious diseases, such as convulsions, or diseases in the bowels. Some children, of a very irritable habit, have the rectum spasmodically affected at times, on passing the fæces, which may be followed by a convulsion. This being frequently repeated, the child becomes afraid to go to stool, and retains the fæces as long as possible, which induces a costive state. Sometimes the terror is so great, that the child can only be made to pass the fæces when half asleep.

In hereditary costiveness, it is difficult, if not impossible, to induce a regular state of the bowels; and perhaps in some cases, this, if it could be done, would, seeing that it is not



natural to the constitution, be injurious to the child. But we must beware, lest, by indulgence, this habit increase. Whenever the child is pale and puny, or dull, and does not thrive, there is risk of convulsions or some severe disease being induced. At a more advanced period of childhood chorea may be produced. Acquired costiveness may be overcome by medicine, and encouraging regular attempts to procure a stool. A variety of means have been employed in these cases, such as suppositories, magnesia, and other laxatives. The best remedy for changing the state of the bowels seems to be calomel, which may be given in a suitable dose, even to an infant, for a day or two in succession, and then omitted; employing in the interim a little manna alone, or combined with castor oil, and sometimes magnesia may be substituted for a change. In more obstinate cases, infusion of senna, or two or three grains of aloes may be given. A quarter of a grain of ipecacuanha, mixed with sugar, may also be tried. It is also proper to change the nurse, or alter the diet of the child, giving barley-meal porridge, veal soup, ale-berry.

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## CHAP. XV.

### *Of Cholic.*

CHOLIC is a frequent complaint with children, especially when they are costive. It is often produced by too much food, exposure to cold, irregularities in the diet of the nurse, or some bad quality of her milk. It makes its attack suddenly, and is known by violent screaming, induced without any warning, and accompanied with hardness of the abdominal muscles, kicking, and drawing up of the legs, and often suppression of urine. These symptoms are soon removed by a clyster or suppository, which brings away both fæces and wind. The warm bath, fomentations, and friction on the belly with anodyne balsam or laudanum, will be serviceable; and if the pain continue, two or three drops of tincture of opium, or a rather larger dose of tincture of hyocyamus,

with oil of anise, may be given. When the child is constive, a laxative is to be exhibited after the anodyne.

If a child be subject to repeated attack of cholic, a few drops of tincture of asafoetida are useful, and we must always take care to prevent the long continuance of pain, as it may end either in visceral inflammation or convulsions.

## CHAP. XV.

### *Of Peritonitis.*

PERITONEAL inflammation, or enteritis is not an uncommon complaint with children. It begins with violent pain in the belly like cholic, but is more constant and continued, and is accompanied with a considerable degree of fever, costiveness, and tenderness in the belly. If this disease do not prove speedily fatal, and if on the other hand, it be not perfectly removed, the child remains long ill, perhaps for some weeks, and the nature of the complaint may for a length time be mistaken. There is constant fever, but it is subject to exacerbation in the evening. There is increasing emaciation, and occasional attacks of pain in the belly. The stools are usually obstructed, and when they are procured, they are slimy, bloody, ill coloured, or scybalous. On examining the belly externally, induration may sometimes be discovered. The appetite is lost, the thirst is considerable, the pulse becomes more frequent and feeble, the debility increases, and the extremities become cold, and in this exhausted state, the child sometimes lies for many hours before dissolution. On inspecting the abdomen, the bowels are found adhering, or forming knots, and sometimes the liver partakes of the disease.

In younger infants, the consequences of peritoneal inflammation, when it does not prove rapidly fatal, or excite convulsions, are obstinate slimy purging, vomiting, and increasing emaciation.

In young infants, we cannot carry evacuation far. But whenever there is a prolonged attack of colic, we may ap-

prehend a severe disease, and must use the warm bath, clysters to open the bowels immediately, and then an opiate clyster to allay morbid sensibility; a small blister should be applied to the belly, and if the symptoms be very urgent, this may be preceded by leeches, though these are rarely in infants required. In elder children, the attack is often brought on by cold, or by eating indigestible substances, as for instance, nuts. No time is to be lost in opening the bowels by clysters and laxatives, and in detracting blood from a vein. Fomentations and blisters are useful. If these means be neglected, or do not succeed, there is little hope afterwards of saving the patient, unless the bowels adhere to the abdominal muscles and an abscess takes place, which is indeed very rare. In the usual state produced by this disease, we have little in our power, except to regulate the state of the bowels, apply small blisters, and support the strength.

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## CHAP. XVI.

### *Of Marasmus.*

CONNECTED with, and generally dependent on, a morbid state of the bowels, is the marasmus, or wasting of children. This disease is preceded and accompanied by costiveness, sometimes alternated with a diarrhoea, in which the stools are foetid, or unnatural in appearance. It begins with lassitude and debility, loss of appetite or depraved appetite, foetid breath and foetid stools, tumid belly, pale leucoplegmatic countenance, with swelling of the upper lip. Presently fever supervenes, the countenance becomes at times flushed, and the skin hot and dry, with frequent pulse, thirst, restlessness, picking of the nose, and disturbed sleep, in which the patient grinds his teeth and starts. The debility gradually increases, and if relief be not procured, death, preceded by great emaciation, takes place. This disease is most frequent with those who are fed on improper food, or eat many raw roots; or much unripe fruit; or those who have the di-



gestive faculty impaired by confinement, bad air, or neglect of the bowels. It very often is considered as produced by worms; but these, although they may often exist in the bowels, are by no means essential to the disease.

This disease may, in the commencement, and before the appearance of fever, be arrested by a course of active purges, given at proper intervals; at the same time that we give light nourishing diet, and inculcate the necessity of exercise in the open air. In the febrile stage, the cure is more difficult, but is to be accomplished on a similar principle, by attending to the state of the bowels. For this purpose, purgatives must be frequently repeated, especially calomel; and here it is necessary to remark, that the stools are not always hard; they are often fluid, but generally foetid, and dark in the colour. A course of purgatives, however, by degrees procures discharge of fæces of natural appearance. Whilst this course is conducting, the strength is to be supported by proper diet, and the prudent use of wine. The power of the stomach may be increased by chalybeates or other tonics, provided these are not nauseated by the patient. After recovery has taken place, we must, by very gentle laxatives, preserve an open state of the bowels, which will prevent a relapse. Sea bathing is likewise of advantage.

The state of the bowels which gives rise to marasmus, sometimes produces speedily more acute symptoms. These constitute a very frequent species of fever, which we shall afterwards consider.

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## CHAP. XVII.

### *Of Tabes Mesenterica.*

*TABES mesenterica*, or hectic from disease of the mesenteric glands, is a very frequent disease. It is not often met with before the time of weaning, nor after puberty, seldom after the age of eight or ten years. The disease consists in enlargement of the mesenteric glands\*, which are sometimes

\* This state is sometimes accompanied with swelling of the thymus gland, and the lymphatic glands of the neck. Swelling of the thymus gland, by

universally affected, but are especially enlarged into a hard mass about the root of the mesentery. These tend slowly to the formation of a cheesy substance, but death may take place before that process be accomplished. The commencement of the disease is slow and obscure; the patient complains of little or no pain, but is subject to an irregular state of the bowels; is either costive, or passes dark loose fæces; is unhealthy in his appearance, and liable to occasional attacks of fever. The urine is white or turbid. The appetite is not much diminished, and digestion goes on; but the belly is hard, and somewhat tumid. The child is more fretful than usual, and sometimes, especially if very young, is troubled with vomiting. This is the incipient stage, and resembles very much that of marasmus, proceeding from affection of the bowels, independent of diseased glands. As the disease advances, the body wastes away, the face is pale, and the features become sharp, the abdomen gradually enlarges more, and the patient complains of lancinating pains, of short duration however, within the belly, or near the back. The stools are now sometimes bound, but oftener loose, frothy, and mixed with bile; occasionally the patient has diarrhœa, with vomiting. The fever, which at first is obscure and intermitting, becomes more acute and distinct, with exacerbation in the evening, attended with restlessness and acceleration of the pulse, which rises to 120 strokes in a minute, or even more. The patient is listless, and his mind becomes gradually inactive, though he does not lose hopes of recovery. The tongue is generally clean, but sometimes covered with a white or brown crust, especially in the middle; and in an advanced stage, the whole mouth and throat become aphthous. The thirst is trifling, but the appetite is usually impaired, and a short cough supervenes. As the disease proceeds, the emaciation of the body increases, the eyes are sunk and glossy, the nose sharp, and apparently elongated, the face sallow, but the lips are sometimes florid, and the cheeks flushed at night. The ab-

pressing on the trachea and œsophagus, produces difficulty of breathing and of swallowing, and sometimes suffocation. By pressing on the subclavian vein, it obstructs the passage of the chyle, and may thus excite disease in the mesenteric glands. Blisters applied to the top of the sternum sometimes do good.



domen is hard, and sounds like a drum when struck upon, or if not very tense, knots may sometimes be felt within it\*. The urine is lessened in quantity, and it often deposits a white or lateritious sediment, the feet swell, and during sleep, the forehead, scalp, and sometimes the breast, are covered with a profuse sweat, whilst the rest of the skin is hard and dry. The progress of this disease is not always alike rapid. In some cases, the patient lives for a year or two in bad health ; but in general, after hectic has appeared, a few months, sometimes weeks, cut him off.

In the commencement of this disease, the steady and repeated use of mild purges of calomel, conjoined with some light bitter infusion, decoction of bark, tonic medicines, and gentle frictions over the belly continued for a considerable length of time, morning and evening, would appear to be of more service than any other plan of treatment. It has been proposed to give calomel in small doses, as a mercurial ; but it does not appear to have great efficacy, and is chiefly of use, in so far as it acts as a gentle purgative. Copious evacuations in this disease are not required. It is sufficient that the bowels be brought into, and kept in a regular state, which, in the incipient stage, at least, sometimes requires pretty strong doses. But in the confirmed and advanced stage, stools are easily obtained ; and from the loose state of the bowels which often prevails, it comes to be a question, how far laxatives are proper. Upon this important subject, I observe, that these medicines ought not to be severe, but gentle, and given frequently, provided they have the effect of diminishing the tumor of the belly, making the stools more natural, and do not impair the strength. The lax stools which take place in this disease spontaneously, never abate the tumefaction ; but a gentle course of laxatives often does, and this is a most favourable effect. Farther, if the paroxysms of fever be severe, and early in their appearance, we find it necessary to use purgatives more freely than in opposite circumstances ; evacuation by stool being in such

\* Sometimes a hard tumor may be felt within the belly, pretty early in the disease. It is often felt in the right side, near the origin of the colon,



cases advantageous. In the confirmed and advanced stage, it is sufficient that such a dose of calomel be given every night, or every second or third night, as shall keep the bowels open if disposed to be costive, or, if loose, to make the stools more natural in their appearance than they would be without the administration of medicine. We must, however, take care, that the mercury do not excite much effect on the constitution, lest debility be increased; it is therefore prudent, sometimes to combine the calomel with rhubarb, or to employ a little castor oil emulsion. Along with this plan, we may, in every stage of the disease, derive advantage from the use of tonic medicines, such as bitters and chalybeates, especially in the form of mineral waters. But the last are to be used cautiously, if there be marks of inflammation existing in the glands; and in such cases, some light bitter infusion is preferable to chalybeates. In such circumstances, the laxatives are to be used more freely, the tepid bath is to be employed, and the belly rubbed freely with anodyne balsam. Gentle exercise in the open air is of great service, and it is useful in the early part of the disease to reside near the sea; but if the glands seem to be in a state of inflammation, discovered by shooting pains with fever, the patient must not bathe; and indeed, at all times, the utility and safety of the cold bath seems to be doubtful, except when the disease is so far removed, that we have chiefly to contend with debility. The warm bath is more generally useful. The diet should be light and nutritious, but all stimulating and indigestible substances must be avoided. If an inflammatory state exist, milk in different forms, soft boiled eggs, and vegetables, are proper. If no inflammation be present, some animal food will be of service; nay, as in other scrophulous affections, a very considerable proportion of animal diet is sometimes beneficial, in preventing the tumor from inflaming and forming a cheesy substance, or in giving a favourable turn to the action, when the acute state of inflammation has abated, in those cases where it is met with, for it is by no means an universal occurrence.

In the latter end of the disease, little can be done except palliating symptoms, and supporting the strength by soups and a little wine. Diarrhœa should be restrained by anodyne clysters.

Cicuta, burnt sponge, and some other medicines, have been advised in this disease, but I cannot say that they have been employed with advantage. Electricity is sometimes of service.

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## CHAP. XVIII.

### *Of Worms.*

Worms exist in the bowels, perhaps, of every child\*, but especially in those whose bowels are debilitated by bad management, or by acute disease; and hence, in the end of disease, or after recovering from such illness, worms are often expelled, both by children and adults. Worms are of different kinds, but infants are chiefly infested with lumbrici and ascarides, the teniæ being rarely met with until children are six or seven years old. We also sometimes meet with some uncommon species of worm, which are ejected by vomiting, and some lususes have been passed by stool; thus, for instance, I have seen a worm about three inches long, having two large flat heads, with two bodies, separated for a little, and then united in a common trunk, ending in a tapering tail. Insects of different kinds may also be introduced accidentally into the stomach and bowels, and live there for some time.

Ascarides generally occupy the rectum, producing much itching in that part, so that sleep is often prevented. The irritation causes indigestion and pain in the belly, with picking of the nose and white face, a variable appetite, and sometimes a desire for indigestible substances. The worms are discovered in the stools like small white threads, and occasionally they creep out from the rectum. The stools are often slimy or mucous. This kind of worms is removed by

\* Worms rarely appear in the bowels, till after the child is weaned.

injections of aloes mixed with water, or any strong bitter infusion; lime water and olive oil also sometimes destroy them, but cannot be depended on. Calomel purges are proper likewise; and any disordered state of the alimentary canal, which exists, is to be treated on general principles.

The *ascaris lumbricoides* is often from six to ten inches long. In its general appearance it resembles the earth worm, but differs from it, in having, besides other distinctions, a longitudinal line on each side, whereas the earth worm has three lines on the upper surface. It dies soon after its expulsion, but when alive, it moves like an eel, and does not shorten the body like a worm. Dr Hooper, in the 5th vol. of the Mem. of Med. Soc. has a valuable paper on intestinal worms. Lumbrici may exist in every part of the alimentary canal, and frequently are ejected by vomiting, as well as by stool. The symptoms are those of intestinal irritation\*, pains in the belly, frequent attacks of diarrhœa, variable, and often voracious appetite, the child sometimes becoming hungry almost immediately after having ate heartily, fœtid breath, pale complexion, tumor of the lips, with livid circle round the eyes, swelling of the belly at night, and disturbed sleep, the child occasionally awaking in a great terror, and being liable to starting and grinding of the teeth. When awake, he picks his nose, is plagued with temporary head-ach, sometimes has a dry cough, with slow fever, or convulsive affections. I have already pointed out several diseases proceeding from disorder of the bowels, and these may arise from worms, in as much as they are capable of irritating the bowels, or injuring their action, or increasing such a debilitated state, as may have predisposed to their accumulation. A variety of anthelmintics have been advised; for an account of which, I refer to the writers on the Materia Medica. Sulphur, tansy, aloes, *spigelia marylandica*, *dolichus pruriens*, the *gœffrea*, worm seed, tin powder,

\* Hence it is not easy to say that worms are the cause of a child's complaint, for other morbid affections of the bowels produce the same symptoms. A course of purging removes these symptoms, without bringing away any worms; although the slimy appearance of the stools is often attributed to the worms being dissolved.



filings of steel, &c. have at all times a good effect; but in general, calomel purges given repeatedly and liberally, provided the constitution of the patient will bear them, will be found very effectual; or these may be alternated with saline purgatives, or suitable doses of aloes or jalap. In obstinate cases, much benefit will be derived, by giving a regular course of purgatives, so as to keep up a constant but gentle effect on the bowels. After the worms are expelled, a bitter infusion, or chalybeate water, will be useful to strengthen the bowels, or these may even be employed whilst we are using the purgatives.

The trichuris, or long thread worm, is about two inches long, and two-thirds of this forming a tail like a hair. The body is about the 16th of an inch thick, and the worm is white like the ascaris. It is found in the rectum, and also higher up, even in the ilium.

The tænia consists of many flat jointed portions, and is divided into the T. Solium, where the orifices are placed on the margins of the joints, and the T. Lata, where they are found in the surface. The usual symptoms, are produced, and the usual remedies are required; but the tænia is more difficult to be removed than other worms.

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## CHAP. XIX.

### *Of Jaundice.*

THE jaundice of infants is a disease attended with great danger, especially if it appear very soon after birth, and the stools evince a deficiency of bile; for we have then reason to apprehend some incurable state of the biliary apparatus. I conceive that there are two species of this disease, which are very opposite in their nature. In the first, there is an obstacle to the passage of the bile into the intestine, the child is costive, and the meconium is paler than usual, and after it is removed, the stools become light coloured; the skin, very early after birth, becomes of a deep yellow colour, which extends to the eyes. The child sucks very little, has

occasionally a difficulty in swallowing, is languid, becomes emaciated, moans much, is troubled with flatulence, sometimes with cough and phlegm in the trachea, or vomiting, convulsions, cholic, and fever, occasionally supervene. In some cases, the liver is felt enlarged, and the hypochondrium is tumid. The water is very high coloured. This disease often proves fatal in a week, but it has been known to continue in variable degrees of violence for a considerable time, and at last to disappear, though such children continue long delicate. With regard to the cause of this disease, we find, that sometimes it consists in obstruction of the hepatic duct, or ductus communis, either by thickening of the coats, or pressure, in consequence of enlargement of some part in the vicinity of the duct; or it may consist in imperforation of the duct. Sometimes it proceeds from temporary obstruction in the duct, owing to viscosity of the bile. Now some of these cases are irremovable, others are not; but as we cannot *a priori* say what the cause may be, in any particular instance, we must use the means of cure in every case. The most likely remedies for removing this disease, are gentle emetics, given very early and followed by the exhibition of half a grain of calomel, morning and evening, till the bowels are acted on; or we may give this medicine even three times a-day, in some cases; but we must be cautious not to induce much purging, or push the mercury far, lest we bring on fits.

The second species differs from the first, in the stools being dark coloured or green, shewing that there is no obstruction, or at least no permanent obstruction, to the passage of the bile \*. Like the first species it appears soon after birth, and is accompanied with great oppression, moaning, colic, and convulsive affections. It is attended with much danger, and frequently carries off the infant in a few days. The early use of calomel would appear to be the most proper practice, and the strength must be supported

\* It is in this species alone that the opinion can be admitted, that infantile jaundice depends on absorption of bile from the intestines.

in all those cases by the breast milk, given with the spoon, if the child wont suck, and small doses of white-wine whey.

Jaundice, appearing at a considerable period after birth, does not require a separate consideration here, nor is it a very common occurrence.

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## CHAP. XX.

### *Of Diseased Liver.*

ENLARGEMENT and inflammation of the liver are not uncommon in infancy and childhood, but the first is most common in infancy. It is productive of vomiting, oppressed breathing, cough, fever, and sometimes purging. The liver can be felt enlarged, and extending lower down, or more to the left side than it ought to do, which will distinguish this complaint from inflammation of the lungs, which is also not so frequently attended with vomiting\*. I cannot say much that will be satisfactory respecting the treatment. Mercurial friction is chiefly to be relied on.

Hepatitis in infancy is marked with the symptoms attending enlargement of the liver; but there is more fever, and sometimes pain, when the liver is pressed on. The disease often begins with symptoms of disordered stomach, and colic pain. Fever comes on, accompanied with cough, which is sometimes soon succeeded by jaundice. The stools are often like yolk of egg, or, if there be obstruction to the passage of the bile, they are clay coloured, and the urine red, with much sediment. On inspecting the body of infants who have died of this disease, the surface of the liver, sometimes only its convex surface, is often found of a deep red colour, with an exudation of white lymph, exactly resembling the cuticle of a blistered part. Betwixt the liver and diaphragm, we find white flaky fluid, something like pus, and similar matter is often found among the bowels,

\* On examining the liver, it is sometimes found soft, and not much altered in structure, sometimes hard, and almost cartilaginous, with the pori biliari, hardened and obstructed, so that secretion of bile does not take place, and the gall bladder becomes shrivelled. This state cannot be attended with jaundice



mixed with pieces of fatty-looking lymph. The liver is not necessarily enlarged, nor its substance affected. The stomach and bowels are not inflamed, but sometimes have a white blanched appearance, and contain a fluid like thin custard. The bile is not changed in its colour. In some instances of chronic inflammation, the liver is somewhat enlarged, of a dark colour, and the veins turgid. Blisters, laxatives, and a gentle course of mercury are the principal means of cure. In older children we find hepatitis to commence either acutely or slowly. When it begins acutely, the child probably after a surfeit, or some irregularity of diet, or exposure to cold, complains of severe pains in the upper part of the belly, like colic, accompanied with sickness and vomiting; and either attended, or soon succeeded by fever, short cough, and pain, sometimes dull, sometimes sharp in the right side, and occasionally affecting the shoulder. Jaundice also, not unfrequently, is produced and lasts for a few days. There is thirst, no appetite, but the child feels continually as if he had ate too much, is subject to fits of squeamishness, and complains when the liver is pressed. If the remedies do not check the disease, the liver enlarges, and its region is full; abscess is formed, attended with irregular chilliness, hectic symptoms, and much pink coloured sediment in the urine. In a few weeks, sometimes in a shorter period, the patient is sensible of a smell like rotten eggs, which he thinks comes from the stomach; then a little foetid matter is coughed up, which is followed by copious expectoration; or he ejects pus as if he vomited it from the stomach. The cough and spitting, with hectic symptoms continue long, but at last decline and go off.

In the early stage, blood letting, if instantly resorted to, may be of service, but not if delayed. Blisters are always proper. The bowels should be freely opened, and afterwards a gentle course of mercury employed. In the suppurating stage, mercury should not be used, but the strength is to be supported by proper diet. In the expectorating stage, the same plan is necessary, with the use of tonics, such as chalybeates joined with myrrh, and occasionally opiates. A

speedy removal to the country, if the weather be mild, is advantageous. Sometimes the abscess bursts into the stomach or intestines, adhesion previously taking place; or, I have known it burst into the general cavity of the abdomen, and the matter accumulate there, forming a tumor like ascites, bursting at last by the navel, which inflamed; or it has been drawn off with a trocar, and recovery has been accomplished.

The more slow or chronic species may be excited by a torpid state of the whole chylopaetic viscera, consequent to neglected bowels, or other causes; or it may occur after some other disease, such as peripneumony, scarlatina, &c. The child has fits of sickness, vomits bile in the morning, and loses his appetite; or if he has a strong desire for particular kinds of food, or feels very hungry at times, he either cannot eat when he receives food, or is instantly filled. The strength diminishes, the bowels are torpid, and the stools white, in some cases bilious, or dark and offensive; in others there is a constant dry cough, and inclination to hawk or spit, the pulse is frequent, the upper part of the belly becomes swelled at night, but there is little or no pain in the region of the liver; if any be felt, it is rather referred to the bowels. By and bye considerable pain, like colic, is felt near the stomach, especially at night, and that part of the belly is then swelled, but towards morning it subsides. On examination, however, the hypochondriac region is felt full, and the liver can be perceived extending towards the left side, and pain, and sometimes sickness, are produced by pressure. The urine is high coloured, the feet swell at night, and the face has a slight hectic flush. If the disease be not checked, it goes on to suppuration, producing distinct hectic fever, terminating in death, if the matter be not discharged; or, it may be, irritation proves fatal, even without suppuration. Repeated blisters, laxatives, and mercurial inunction are the remedies, with diuretics, if there be dropsical symptoms.

The spleen is frequently enlarged, and sometimes contains tubercles. I do not know any other diagnostic symptom, than the belly being tumid and hard in the region of the

spleen; frequently a cough attends this state. Mercurial laxatives, and blisters, are the best remedies, but most cases I have met with have proved fatal.

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## CHAP. XXI.

### *Of Fever.*

FEVER is a frequent disease in infancy and childhood, but it is generally symptomatic, or produced by some local irritation. Typhus fever is extremely rare in infancy, but it sometimes is communicated to children a few years old. It is known by our evidently tracing the channel of infection. The child at first is languid, pale, chilly, and debilitated, the appetite is lost, the head becomes painful, the skin hot, the tongue foul, the eye dull, or suffused, and the pulse very quick; and if a favourable crisis be not procured, great oppression, succeeded by stupor, precedes death. In the course of the disease, the bowels are generally bound, the stools foetid, and the urine thick. It requires the early use of emetics in the cold stage, succeeded by saline julap. If the hot stage, however, be fully established, and the heat considerable, the affusion will be of advantage, succeeded by calomel purges and saline julap, with light diet, and the use of ripe fruit. A free circulation of air is of essential benefit. The skin, in the course of the disease, especially among the poor, should be sponged daily with tepid water, and the bed-clothes, if possible, changed frequently. If the head be very painful in the first stage, the application of leeches to the forehead and the use of laxatives will be useful. If pain continue, or stupor, or constant drowsiness supervene, blisters will be proper. The strength, in the latter end of the disease, is to be supported by the prudent use of wine. Cough in general requires blisters to the breast, with squill vinegar.

The most frequent fever, however, excluding those accompanied with eruptions, is the fever from irritation, which, although it may proceed from various causes, is essentially the same in its nature, and the indications of cure.



It has of late years been described under the name of the infantile remittent fever, though the fever so described belongs to childhood, rather than infancy. It will be useful to divide the fever, at present to be considered, into that variety which occurs in early infancy, and that which takes place in childhood. With regard to the description of the first variety, it is very similar to the early stage of hydrocephalus, but the remissions are more distinct in the morning, and the exacerbations greater in the evening. The pulse is very quick \*, the skin hot, the mouth warmer than usual. The child is at first fretful, restless, costive, and inclined to vomit; then he becomes more oppressed, and in some cases has slight cough, with increased secretion of phlegm in the trachea; perhaps, he does not for hours lift his eyes, till the remission comes, when he looks up, and attends to the objects presented to him for a short time. He sucks in general freely, and sometimes bites the nipple, and very often aphthæ appear in the mouth. The bowels are irregular, but whether the stools be frequent or seldom, they are generally green or brown, and offensive. The urine is usually high coloured and scanty, and sometimes the feet swell a little, and very often become cold. If the disease prove fatal, it is generally attended, in the end, with symptoms of effusion into the ventricles of the brain, or the infant is exhausted gradually by the continuance of the fever, or more quickly by the accession of obstinate diarrhœa. A favourable change takes place, sometimes about the fifth day, sometimes later, the child looking up for a longer space of time than formerly, and seeming more free from sickness. After this, the symptoms subside, and the strength is gradually restored. It is very common to find, that at this time, one or more teeth have made their appearance. In many cases, the fever may proceed from affection of the bowels; but frequently it is caused by dentition, the irritation in the jaw operating either alone, or in connexion with a morbid state of the bowels. In this kind of fever, the gums should

\* In the early stage of hydrocephalus, the pulse is more irregular, and often beats alternately quick and slow, for two or three pulsations,

be carefully inspected, and, if necessary, cut. Small doses of calomel should be given morning and evening, mixed with magnesia, to prevent costiveness, or evacuate irritating fæces. A few drops of tincture of hyocyamus, with a saline julap, may be given occasionally to abate irritation. The tepid bath should be employed once a-day, when the exacerbation takes place, and the strength supported by the breast milk or beef tea. If the child be plethoric, a leech should be early applied on the forehead; and if a favourable crisis do not soon take place, the head ought to be blistered. In some cases, although the acute symptoms go off, the child does not recover, but remains fretful, languid, and emaciated. The eyes are suffused, the feet swell, and the stools are not regular nor natural. In some instances, tumor of the mesenteric glands seem to be excited.

The remittent fever of older children is met with from the age of two to ten or twelve years, and is generally found to be produced, either speedily after eating some improper substances which have not been immediately removed from the stomach or bowels, or gradually by the induction of a costive state, or the accumulation of irritating fæces in the bowels. In the first case, the fever attacks suddenly, sometimes through the day, but generally at night, and the child is sick, pale, very restless, extremely hot, disturbed in the sleep, and thirsty. Sometimes he vomits, or complains of head-ach, or pain in the belly. The tongue is at this time tolerably clean, but next day it becomes furred, and the fits of vomiting or sickness are pretty frequent. They are generally preceded by head-ach, which goes off or abates after throwing up. If this disease be attacked immediately with an emetic, followed in the morning with a smart purge, the health is soon restored; but if the remedies be delayed till the next day, I have generally found, that although the emetic, with purging, mitigates the disease, it does not arrest it speedily, but, notwithstanding the regular use of laxatives with diaphoretics, it continues for several days. Emetics and purgatives, in this disease, generally bring off some half-digested substance, such as almonds, orange peel, &c.

It is astonishing how torpid the bowels sometimes are, large doses of medicine, either producing no effect, or lying for some time inactive in the stomach, they are then vomited. In such cases, strong clysters are proper to assist the physic.

In the second case \*, the attack is often more gradual; the child being for several days somewhat feverish and unwell. The pulse is frequent, and, in the course of the day, he has several attacks of feverishness, during which he is dull, and disposed to sleep or lie down; but these do not last very long, and in the interval he seems tolerably well, but is easily put out of temper, and complains when lifted or touched, though he is not hurt. The appetite is not steady, he has little thirst, and the tongue is clean. The bowels are sometimes very open, but oftener bound. These symptoms appear more or less distinctly for about a week, though sometimes not so long. Then an acute paroxysm of fever takes place, preceded by shivering, and attended generally by vomiting. The pulse becomes much more frequent, sometimes 140 in a minute. The cheeks are flushed, and the patient is very drowsy, but complains of little pain in the head, or indeed any where, except occasionally in his belly, which may at times be very severely pained; or if he complain of headach, it is evidently from his stomach, for it is followed by sickness or vomiting. The fever does not continue alike severe during the whole of the day; it remits a little, but not at very regular hours. The exacerbation which usually occurs in the afternoon, is generally accompanied with drowsiness. Very soon after the attack of fever, the tongue becomes covered with a white or brown coat, and both the stomach and the bowels seem to be extremely torpid. The appetite, indeed, is soon almost totally lost, or the food which is taken is not digested. The bowels are generally, but not always costive; and the stools are fœtid, dark-coloured, sometimes like pitch, or thin and olive-coloured, or green and curdy-looking. There is a great desire to pick the nose and

\* This is commonly called a worm fever, although worms are not necessarily passed in this disease.



lips; and if the child be not watched, sometimes an ulcer is thus produced upon the lips or angle of the mouth.

The face is flushed during the exacerbation; but, except at this time, it is pale. The eyes are dull and white; though sometimes, in the course of the disease, they are unusually clear. Generally, delirium occurs in the advanced stage of the disease, and in some cases it is difficult to keep the child in bed. From this state, however, he can usually be recalled for a few minutes, and will then answer questions distinctly. If the debility be considerable, the countenance becomes vacant, the child picks at the bed-clothes, and though he does not speak much, makes a constant inarticulate noise. In some instances, convulsions have taken place; but these are rare, and are chiefly met with in young children. Sometimes the stools are passed in bed, without any intimation being given. This disease runs on for a week or two, or even for several weeks, and may at last destroy the patient by debility; an event which will take place earlier, if the proper remedies are not employed, than if they be, even although they may ultimately fail. In general, success attends their use. Tumefaction of the belly, with great and constant fever, are very unfavourable.

This fever bears a very considerable resemblance to hydrocephalus. But in hydrocephalus there is a more frequent vomiting, and as often a tossing of the hands above the head as picking of the nose or lips. There is pain of the head, which is wanting, or if it occur early, it is, in this fever, in paroxysms connected with sickness, or affection of the stomach. There is screaming and strabismus, and often a more constant delirium, from which the patient cannot be roused, after it has continued for some time; and convulsions are accompanied with great injury of the mental faculties. There is in general more complete remission of the symptoms at some time of the day than in water in the head, the pulse not only being slower, but the child more lively and easier. The stools are more foetid and darker in this fever than in hydrocephalus, in which they are often thin and bilious, and sometimes glossy. The pulse in hydrocephalus is more ir-

regular, and, in the second stage, usually becomes slow and intermittent. It must, however, be acknowledged, that, in some instances, it is very difficult to make the diagnosis, especially if we have not attended the child from the first. I have had the happiness of seeing children recovered from situations apparently desperate, when there was every reason to fear that the disease was water in the head, though the result proved the contrary. Fortunately, in all such ambiguous cases, the exact diagnosis would be of more consequence in determining the prognosis than the treatment. For, in these circumstances, the application of blisters to the head, the use of laxatives, and supporting the strength, are the means to be chiefly resorted to in both diseases.

It is generally proper to begin the treatment of this disease, on its first attack, with an emetic, which is to be followed with a purgative. In some cases, the usual dose of the purgative will prove effectual; but oftener a much larger quantity must be given. We cannot *a priori* say what quantity may be necessary to procure stools. Usually, it is great beyond what any one who has not seen much of this disease would expect. Senna tea answers the purpose very well; or if the child can swallow pills, the aloetic pills stay well on the stomach, and, if given in sufficient number, act excellently on the bowels. Clysters are also useful. It is useful to evacuate the bowels freely at first; but after this, it is not proper to give so much medicine as will purge briskly.\* It is requisite, however, to give regularly such doses as will keep the bowels open, and support their action. When the stools are loose, purgatives are still proper, in prudent doses, to evacuate them; for they are not natural in their appearance, and injure the action of the intestines. Suitable doses of calomel, or castor oil emulsion, or infusion of senna, or aloetic pills, will presently bring the stools into a more natural state. This is a very important part of our practice, but not the whole of it, for we know well, that re-

\* Dr Femberton judiciously remarks, that if strong purges are given, the intestines are apt to become distended with air, and the patient is destroyed with tympanites. Practical Treatise, &c. p. 165. It is worthy of remark, that dissection often discovers nothing but great inflation of the intestines.

moving the cause of fever does not always remove the fever itself. We should therefore, besides using laxatives early, and continuing their exhibition during the disease, as long as these bring away offensive stools, and do not increase the frequency of the pulse or debility, have recourse, in the commencement of the fever, to the use of the sponge, with cold water to moderate the heat. This is to be repeated oftener or seldomer, according to the benefit it produces. If the first application gives much relief, we may even employ the affusion of cold water prudently, immediately after the hot stage is established, and then it may abate the fever. Afterwards we employ saline julap, with a little antimonial wine, and, in the more advanced stage support the strength with regular and cautiously proportioned doses of wine. Opium and hyocyamus frequently allay irritation, and accelerate recovery, by procuring sleep. Anodyne elysters are useful in this respect, and also for abating griping or abdominal pain. This also is relieved by fomentations. Pain in the side, if not abated by rubbing with anodyne balsam, requires a small blister. Delirium is sometimes, but not always, mitigated by blistering the head; but this is uniformly proper when there is considerable delirium, or any pain in the head. Shaving the head, and merely washing it with vinegar, has also a good effect. The diet should be light, but it is not proper to force the patient to eat. In the progress of the disease, infusion of bark or other tonics are sometimes beneficial. Great attention should be paid to cleanliness and ventilation, and, when convalescent, a removal to the country is highly useful.



# NOTES.

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## BOOK I.

### CHAP. II.

NOTE 1, Page 12. Dr Denman mentions an instance, where the patient, in three succeeding pregnancies, was progressively worse, and did not, until the lapse of eight years, recover from the lameness produced by the third delivery. *Introd. Vol. I. p. 16.*

NOTE 2, p. 12. In one case, where the symphysis was divided, the patient was able to walk on the 15th day.—In Dr Smollet's case, although in the 8th month of gestation, the bones were found to rise above each other, yet the woman recovered in two months after delivery. *Smellie, Vol. II. coll. 1. n. i. c. 2.*

NOTE 3, p. 13. As an illustration of this disease, I shall relate the outlines of a case mentioned by Louis, in the *Memoirs of the Royal Academy of Surgery*. A woman in the 2d month of her pregnancy, after pressing in a drawer with her foot, felt a considerable pain at the lower part of the belly, greatly increased by every change of posture; and along with this she complained of strangury. She was bled, and purged, and kept at rest, by which means, especially by the last, she grew better. But in the two latter months of pregnancy, the symptoms were renewed, so that presently she could neither walk, nor even turn in bed, without great pain; but her greatest suffering was caused by raising the legs to pull on her stockings, as then the bones were more powerfully acted on. A slight degree of hectic fever now appeared. Her delivery was accomplished easily; but on the evening of the 3d day, when straining at stool, after having received a clyster, the pain, which had troubled her little since her labour, returned with as much severity as ever. On the 5th day the pulse was very weak and frequent, she sweated profusely, and had a wildness in her countenance, with symptoms of approaching delirium. In the afternoon the pulse became full and tense, with vertigo and throbbing of the arteries of the head. The pain at the symphysis was excruciating, and although she was fomented and bled seven times, she obtained no relief. On the 8th day the pain abated, but diffused itself over the rest of the pelvis, particularly affecting the left hip and the sacrum. On the 11th day she died. On opening the body, there was found a separation of the bones at the pubis, but the capsule was entire, and much distended. It contained about an ounce and a half of matter. Whether the timeous evacuation of this matter might have saved the patient, is a question worth our considera-

tion. I am disposed to answer it in the affirmative, from observing, that wherever the patient has recovered in such circumstances, it has uniformly happened, that a discharge of matter has taken place.

NOTE 4, p. 14.—Dr Laurence shewed Dr Smellie a pelvis, where all the bones were separated to the extent of an inch.

NOTE 5, p. 13.—In a case related by De la Malle, the pain did not appear till the 14th day after delivery, and was felt first in the groin. The patient was unable to move the leg, and had acute fever, which proved fatal. The sacrum was found separated, three lines from the ilium.

In the operation of dividing the pubis in a parturient woman, it was found that one side yielded more than the other, and consequently that side would suffer most at the sacrum. Baudelocque *L'Art, &c.* section 2063.

NOTE 6, p. 13.—Dr Smellie relates an instance, where, during labour, the woman felt violent pain at the right sacro-iliac symphysis. On the 5th day this pain was extremely severe, and attended with acute fever; but the symptoms were abated by blood-letting, and a clyster, and fomentations, which produced a copious perspiration. She was not able to walk for five or six months without crutches, but was restored to the use of the limb, by means of the cold bath. *Coll. l. n. i. e. l.*

When uneasiness is felt at the pubis, or about the pelvis, during gestation, and there is an apprehension that the bones may separate, it will be proper to bleed the patient occasionally, which may prevent the accident.

## CHAP. VI.

NOTE 1, p. 27.—It is not necessary to give examples of every degree of deformity; but it will be useful to select some specimens of the different kinds. The slighter degrees do not require to be particularized. I shall first of all give the dimensions of a dried pelvis, so contracted, as to prevent a child at the full time from passing without assistance. From the pubis to the sacrum, it measures three inches; from the acetabulum to the sacrum, on the right side, two and an half inches; on the left, two inches and seven eighths; from the brim above the foramen thyroideum, to the opposite sacro-iliac junction, five inches; from the same part of the brim on one side, to the same on the opposite, three inches and an half; transverse diameter, four inches and seven eighths; from the arch of the pubis to the hollow of the sacrum, five inches; from one tuberosity of the ischium to the other, four inches and an half; from one spine to another, four inches and an half; the arch of the pubis is natural. The distance from the face of the third lumbar vertebræ, to the spine of the ilium on both sides, is six inches. These dimensions may be compared with those of the well formed pelvis. The symphysis pubis has the cartilage in the inside, projecting like a spine, which, added to the smallness of the pelvis when recent. The linea ilio-pectinea also, on the left side, is for the length of two inches as sharp as a knife; and from these two causes, the cervix uteri and bladder were torn in labour.

NOTE 2, p. 27.—In a pelvis of this kind, which I shall describe, the vertebræ and sacrum lean much to the left side. The line from the promontory of the sacrum to the part of the pubis opposite it, is barely an inch and an half;

but an oblique line drawn to the symphysis, which is to the right of the promontory, is near two inches. From the promontory to the side of the brim at the ilium on the left side, is two inches and three tenths; on the right side, three inches and four tenths. On the left side, from the lateral part of the sacrum to the acetabulum, is nine tenths of an inch; on the right side, fully two inches. Now in this pelvis, when the soft parts are added, we shall find that an oval body may pass on the right side, whose long diameter is three inches and an half, and whose short diameter is barely two inches.

In a pelvis with a semicircular brim, whose short diameter, at the middle and each side, is one inch and an half, an oval could pass when the soft parts are added, whose long diameter is about two inches and a quarter; and the short one about one inch and a quarter.

NOTE 3, p. 28.—In a well formed pelvis, a line drawn transversely along the brim, and in contact with the sacrum, either touches at its two extremities, the sacro-iliac junctions or the linea ilio-pectinea, about half an inch before them; but in a very deformed pelvis, such a line will touch the brim, at, or even before the acetabula. In a well formed pelvis, a line drawn from the middle of the linea ilio-pectinea on one side, to the same spot on the opposite side, is about an inch, or an inch and an half distant from the sacrum. But in a deformed pelvis, this line would either pass through the sacrum, or altogether behind it.

NOTE 4, p. 28.—The following are the dimensions of a pelvis of this kind, which I select as a specimen. From the spinous process of the ilium on one side to the other, is eight inches and three fourths. From the lumbar vertebræ to the spinous process of the ilium on the right side, six inches; on the left side, one inch and seven eighths. From the spinous process of the ilium back to its ridge, two inches and an half. From the symphysis pubis to the sacrum, one inch and three fourths. From the right acetabulum to the sacrum, six tenths of an inch; from the left, seven eighths of an inch. From the brim above the foramen thyroideum to the same point on the opposite side, seven eighths of an inch. From the same part of the brim to the opposite sacro-iliac junction, three inches and an half on both sides. From the tuberosity of one ischium to that of the other, two inches and an half. From the tuberosity to the coccyx, three inches. From the spine of one ischium to that of the other, three inches and an half. From the lower part of the symphysis pubis to the hollow of the sacrum, four inches; distance of the rami of the pubis, five eighths of an inch.

This pelvis has a triangular brim; for it will be observed, that the brim above the foramen thyroideum measures nearly an inch across, and therefore there is a considerable space betwixt the two ossa pubis, gradually, however, becoming narrower toward the junction of the bones; but little advantage in delivery can be gained from this. When we examine it with a view to determine what bulk may be brought through the brim, we find that it is by its shape virtually divided into two cavities, one on the right, and the other on the left side, and the short diameter of the one is six tenths of an inch, and that of the other seven eighths of an inch; therefore no art can bring a child at the full time through it.



In this pelvis, the sacrum has fallen so forward at the top, that in a standing posture the face of that bone is almost horizontal, and its under part with the coccyx is bent forward like a hook. The vertebræ are much distorted.

NOTE 5, p. 28. This is the case in a pelvis where the distance from the part of the brim above the foramen thyroideum on one side, across to the same part on the opposite side, is only five eighths of an inch. From the right acetabulum to the sacrum is an inch and three eighths. From the left is one inch. This pelvis at the brim is externally triangular, but it is, from the near approximation of the bones, virtually semicircular, the space betwixt the two ossa pubis being so trifling as not to merit consideration; and the diameter of the brim here is one inch, exclusive of the small slit betwixt the bones. The sacrum in this pelvis is very much curved, and the outlet is small.

NOTE 6, p. 30. Dr Denman mentions a fatal case of this kind, to which Dr Hunter was called. The child was delivered by the crotchet, but the patient died on the fourth day. A firm fatty excrescence, springing from one side of the sacrum, was found to have occasioned the difficulty. Vide *Introd.* Vol. II. p. 72.—Baudelocque, in the 5th vol. of *Recueil Periodique*, relates a case, where, in consequence of a scirrhus tumor adhering to the pelvis, the crotchet was necessary. In a subsequent labour, the cæsarean operation was performed, and proved fatal to the mother.—Dr Drew records an instance where the tumor adhered to the sacro-sciatic ligament, and was successfully extirpated during labour. Vide *Edin. Journal*, Vol. I. p. 23.

NOTE 7, p. 30. A fatal case of this kind occurred to Dr Ford, and is noticed by Dr Denman. Vol. II. p. 75.—Another fatal instance is recorded by M. Baudelocque, *L'Art.* section 1964.

NOTE 8, p. 30. Several cases of this kind have been met with, and in one related by M. Brand, and noticed by Dr Sandifort in his *Obs. Anat. Path.* the woman died undelivered.

## CHAP. VII.

NOTE 1, p. 32. The following are the dimensions of a very large pelvis which I possess. The conjugate diameter is four inches and three fourths; the lateral five inches and five eighths; the diagonal five inches and an half. From the symphysis pubis to the sacro-iliac junction, five inches. From the top of the arch of the pubis to the sacrum, is five inches and three eighths. From one tuberosity of the ischium to the other, is five inches and an half; and the arch is very wide. Depth of the pelvis at the sacrum without the coccyx, five inches. Breadth of the sacrum at the top, four inches and seven eighths. Depth of the pelvis at the sides, four inches.

## CHAP. IX.

NOTE 1. p. 41.—In birds, we find that the ovaria contain a great number of yolks of different sizes. Those which are nearest the wide canal called the

oviduct, which leads to the cloaca, are largest, whilst those remote from it are very minute. The full grown yolk is detached from the ovarium, and in its passage down is furnished both with the albumen and the necessary membranes and shell. In viviparous fishes, as the skate, ray, &c. the same structure obtains. These animals have two ovaria, containing eggs of different sizes; the smaller are white, the larger yellowish, and they pass down to an oviduct, which contains a glandular body that furnishes the covering of the egg. Each ovary has a separate oviduct, which forms a vast sac, that terminates in the sides of the cloaca, by orifices that have a duplicature like a valve. The cloaca itself forms an ample reservoir, that seems more like a continuation of the oviduct than the termination of the rectum. In oviparous fishes, the ovaria are known under the name of roes, and all the visible eggs are of the same size, and so numerous, that some contain above 200,000. They are enveloped in a fine transparent membrane; and septa from this envelope, divide the internal parts, and furnish points of attachment to the ova, which are expelled previous to fecundation. These are called oviparous fishes, and have, properly speaking, no oviduct. The ovaria of frogs resemble those of fishes, and the ova are, previous to expulsion, enveloped in a glary fluid. In the slug we find both testicles and ovaria. The ovarium is a grape-like tissue, containing numerous small grains, or ova, attached by pedicles, which are canals that lead into the oviduct. This is a serpentine canal, that after having adhered to the testicle, opens in the common cavity of generation, in which also the penis or duct from the testicle opens, and during copulation, the two individuals mutually impregnate each other. The ovaria of the adder are like strings of beads.

In many quadrupeds, the ovaria contain ova almost as distinct as some of those animals I have just noticed. The hedgehog has an ovarium like a bunch of grapes; and the ovarium of the civet has a knotted surface, and resembles a packet of little spheres: the ovarium of the didelphis is also vesicular. The common sow has also an ovarium somewhat resembling, externally, that of oviparous animals. Most other quadrupeds have an ovarium more smooth and somewhat oblong in shape, and in general the tube and ovarium are unconnected, as in the human female; but in the otter, my brother observed, that both were contained in a kind of capsule formed by the peritoneum, so that ventral extra-uterine pregnancy cannot take place in this animal.

## CHAP. X.

NOTE 1, p. 48. The females amongst the Bosjesmans have the nymphæ sometimes five inches long. Their colour is a livid blue, like the excrescence of a turkey. Vide Barrow's Travels in Africa, Vol. I. p. 279.

NOTE 2, p. 49. On the shores of the Persian gulph, among the Christians in Abyssinia, and in Egypt among the Arabs and Copts, girls are circumcised. Niebuhr says, that at Kahira, the women who perform this operation are as well known as midwives. Travels, Vol. II. p. 250.—Dr Winterbottom, in his account of Sierra Leone, Vol. II. p. 239, says it is practised among the Mandingo, Foola, and Soosoo women.

NOTE 3, p. 49.—M. Causaubon has inserted a memoir on this subject, in

the 1st Vol. of *Recueil Periodique*, which contains several useful cases. In one of these, the tumor was produced in the seventh month by a kick, and terminated fatally by hemorrhage.—In another given by Sedillot, the labia became prodigiously distended during labour, and the head of the child could not be touched. The labia were torn by the attendant. Afterward the child was delivered with the lever.—In cases related by Baudelocque, Brasdor, &c. the tumors were opened, and the vagina plugged, whilst the wound was stuffed with lint dipped in solution of alum, to prevent hemorrhage.

NOTE 4, p. 49. In a case related by Mr. Reeve, the tumor, which I suspect proceeded from the rupture of the nymphæ, was perceived first in perineo, but soon occupied all the left labium, which was enormously distended. The pain at first was so great as to cause syncope. The parts sloughed, and discharged pus and clotted blood. Bark was given, and she got well. *Lond. Med. Journ.* Vol. IX. p. 119.

NOTE 5, p. 49. Vide case by Dr Maitland, in *Med. Comment.* Vol. VI. p. 95.—Dr Perfect relates a case, where it burst itself before the child was born, and discharged much blood, Vol. II. p. 63.—In another, which ended fatally, the tumor burst after delivery, and discharged five pounds of blood. Vide *Plenk Elementa*, p. 111.—Case by M. Sedillot, in *Recueil Period.* Tom. I. p. 260.

NOTE 6, p. 49. Vide cases by Dr Macbride in *Med. Obs. and Inq.* Vol. V. p. 89.

NOTE 7, p. 49. In Mr Blagden's case, related by Dr Baillie, the woman soon after delivery had violent bearing down pains, as if another child were to be born. A monstrous swelling appeared in the right labium, extending to the perinæum. A large incision was made, which did not heal till the 21st day. *Med. and Physical Journal*, Vol. II. p. 42.

NOTE 8, p. 49. Vide *Eichet de Fleehy, Observ.* p. 375. The patient was cured by introducing a compress into the vagina, and dressing the sore with digestive ointment.

NOTE 9, p. 49. Le Dran relates a case, where above 20 ounces of blood were evacuated by incision. *Consultations*, p. 413.

NOTE 10, p. 50. Mr Simmons cut off a clitoris, which formed a tumor nine inches in length, and fourteen in circumference at the largest end. The circumference of the stem was five inches. *Med. and Phys. Journal*, Vol. V. p. 1.

NOTE 11, p. 50. Schmucker's *Miseel. Surg. Essays*, art. XXIII.

NOTE 12, p. 50. Upon this subject, see Arnaud on Hermaphrodites.

In a child aged three years, I found the mons veneris prominent, and, as well as the labia, covered with a considerable quantity of red hair. The labia were large and thick, like those of a grown woman, but shorter. Their inner surface was white and rugous, until near the orifice of the vagina, where the skin was red. At the top the labia divaricated, and shewed a large clitoris, which hung down like the penis; it was upwards of an inch long, and about half an inch in diameter, and furnished with a thick wrinkled prepuce. It had a distinct glans, at the end of which was observed something like a perforation; but on raising it up, this was seen to be only the extremity of a deep sulcus,



which extended all the way to the urethra, or orifice of the vagina. It resembled the male urethra slit up. The sides of this were formed by the nymphæ. A little before the orifice of the urethra, there was a longitudinal eminence, like the *veru montanum*. The vagina was shut up by the hymen. The uterus was large, like that of a girl of fourteen years of age, and was shaped like hers. The ovaria were of corresponding size; one of them lay on the *psaos* muscle, the other was loose in the pelvis. The tubes were fimbriated at their extremity, but in their course were knotted and serpentine, like the commencement of the *vas deferens*. The uterus was very vascular, and had an inflamed appearance. Its mouth was apparently impervious.

NOTE 13, p. 50. The same effect may be produced, by a continuation of the skin being extended over the parts. It must be cut up. See a case by M. Larrey, in *Rapport General de la Societe Philomatique*, Tom. II. p. 86.

NOTE 14, p. 50. Vide case of a patient of Dr Chamberlain's, in *Cowper's Anatomy*.—Case by Mr Fryer, in *Med. Facts and Obs.* Vol. VIII, p. 132.

NOTE 15, p. 50. Case by Mr Sherwin, in *Med. Records, &c.* p. 279.

NOTE 16, p. 50. Case by Mr. Kaeymer, in *Med. Annals*, Vol. VI. p. 347. By Mr Eason, in *Med. Comment.* Vol. II. p. 187, and a variety of other cases. This, in every instance I have known, has been the greatest complaint.

NOTE 17, p. 50. Dr Smellie candidly acknowledges, that in one instance he took the protrusion of the hymen, for the membranes of the ovum, forced down by labour pains. These pains were accompanied with suppression of urine. He let out about two quarts of blood. *Coll. I. n. i. c. 6.*

NOTE 18, p. 50.—In a case related by Benevoli, the belly was very much swelled, and the urine suppressed. He attempted to pass the catheter, but without success. Next day he repeated his endeavour, and pushing with more force than prudence, considering his object, he ruptured the hymen, and immediately a great quantity of dark matter was evacuated, even to the extent of 32 pints.—See also Mr Fryer's case.—Mr Warner relates the case of a little girl, where the hymen was continued half way over the orifice of the urethra. The effects were at first attributed to stone in the bladder; but the nature of the case being made out, she was cured by dividing the hymen. *Cases*, p. 75.

NOTE 19, p. 50. In a case by Mr Bardy, the patient, who was 15 years of age, had every month, for some days, pain in the uterine region. The external parts were greatly protruded and stretched as in labour, and the nymphæ formed merely two lines. The anus was thrust backward and distended, and she passed the urine and fæces with great pain; the hymen from irritation was covered with scab, the health had suffered. Six pounds of thick gelatinous matter were evacuated by incision. *Med. and Chir. Review* for September, 1807.

NOTE 20, p. 51. In Mr Fyney's case, the part to be divided was very thick; and in Dr McCormick's case, the vagina seemed to be in part impervious. *Med. Comment.* Vol. II. p. 188.—In general the membrane is thin.

NOTE 21, p. 51. Vide Mr Niven's case, in *Med. Comment.* Vol. IX. p. 330. The symptoms gradually abated.

NOTE 22, p. 51. M. Banelocque mentions an instance where the hymen resisted, for half an hour, the strong action of the uterus. Note to Section 341.

NOTE 23, p. 53. Upon this subject, vide La Motte's *Traité*; and cases and observations by Noel, Saucerote, Trainel, and Sedillot, in the fourth and seventh Vol. of the *Recueil Periodique*. Dr Denman mentions an instance where the perinæum was not torn up, but perforated by the head.

NOTE 24, p. 53. In a case where the vagina would not admit the point of the little finger, the child was delivered after eighteen hours labour. *Plenk Elementa*, p. 113. See also Van Swieten.

NOTE 25, p. 53. This may produce bad effects, from retention of the menses. M. Magnan relates the case of a girl, aged 22 years, who had been subject to monthly cholics and suppression of urine. An incision was made through the membrane, and two pounds of blood let out. *Hist. de la Societe de Med. pour 1776*, art. II.

NOTE 26, p. 53. In this case the fæces do not always pass continually. The patient has been known not to have a stool once in a fortnight; which probably depended on the fæces being indurated, and the communication small.

NOTE 27, p. 53. In the 33d Vol. of the *Phil. Trans.* p. 142, there is a case related, where there was a kind of double vagina, separated by a transverse septum or membrane. The orifices were very small. During labour, the pain was so great as to produce convulsions. She was delivered, by laying the two passages into one. Chapman relates a case of malformation, where the woman was impregnated, and in labour all the forcing was felt at the anus. From this an opening was made through into the vagina, and the child was born per anum. Portal mentions a girl, who had only a very small aperture at the vulva, for the evacuation of the urine; the menses came from the rectum; nevertheless, she became pregnant. Before delivery, the orifice of the vagina appeared, and she bore the child the usual way. *Precis de Chirurgie*, Tom. II. p. 745.

NOTE 28, p. 54. Richter in *Comment.* Gotting. Tom. III. art. 2, relates a case of a girl aged 20 years, who for three years had been subject to violent pains about the sacrum, with tremors and syncope every month. The vagina was found to be closed at the upper part, in consequence, it was imagined, of a variolous ulcer in infancy. Fluctuation was felt in the vagina, when pressure was made with the other hand on the abdomen. The contraction was opened, and a quantity of blood let out.

NOTE 29, p. 54. In some parts of Africa, the vagina is made impervious, in order to prevent coition. This operation is generally performed betwixt the age of eleven and twelve years. *Brown's Travels*, p. 349.

NOTE 30, p. 55. Burton relates a case, where the prolapsed vagina was mistaken for part of the placenta, and rudely pulled away, by which the vagina and bladder were torn. *System*, p. 170.

NOTE 31, p. 55. Stollers relates a case, where this was complicated with

calculi. These being removed, the parts were reduced, and a cure obtained. Cases, obs. 2.

NOTE 32, p. 56. Mr Henry Watson, in the *Med. Communications*, Vol. I. p. 162, called the attention of practitioners to this disease. In a case he relates, he drew off in the month of June, four gallons of fluid, by tapping the vagina; and immediately after this she passed the urine freely, which she could not do before. She required again to be tapped in two months, and died in November. The left ovarium was found to be converted into a cyst, about the size of a sow's bladder, but it had not been touched by the trocar. In one case, he punctured with a lancet instead of a trocar, but this was succeeded by troublesome hemorrhage. The good effects of tapping are also seen in a case related by Mr Coley, in *Med. and Phys. Journal*, Vol. VII. p. 412. In this two gallons of water were drawn off, and she continued well for five months, after which, dropsical symptoms returned, and although diuretics gave her some relief, yet she was at last cut off. In the case of Mrs Jarritt, related by Sir W. Bishop, in *Med. Commun.* Vol. II. p. 360, pain was felt in the right side of the belly, after parturition, accompanied with tumefaction. In two years the vagina became prolapsed, the tumor being four inches in diameter. The tumor was punctured twice; the first time 46 pints, the second 51, were drawn off. Diuretics had no effect. In a case related by Dr Denman, the woman was pregnant, and no operation was performed. On the fourth day after her delivery, after a few loose stools, she expired. *Introd.* Vol. I. p. 150.

NOTE 33, p. 63. In a case of this kind, described by Mr Patton as a spasmodic affection of the neck of the bladder, calomel appeared to cure the complaint. *London Med. Journal*, Vol. X. p. 360. The use of the bougie may be proper.

NOTE 34, p. 63. Morgagni relates an important case, where there was a hard painful tumor in the hypogastric region, accompanied with fluor albus uterine hemorrhage, and stillicidium of urine. After death, the bladder was found very large and scirrhus, with two large bodies in the cervix, preventing the urine from being retained. The uterus was diseased only in consequence of its vicinity to the bladder. *Epist.* XXXIX. art. 31.

NOTE 35. p. 63. Of this disease I have never seen an instance; but Dr Baillie mentions a case, in which the greater part of the bladder was filled with a polypus. *Morbid Anat.* p. 298.

NOTE 36. p. 64. The patient to whom I allude, had, I understood, four years before her death, been delivered with the forceps, and soon afterwards had incontinence of urine. I found a large perforation in the bladder, exactly resembling the fauces without an uvula. The uterus was a little enlarged and indurated; and its mouth, which was ulcerated and fungous, lay in this opening, projecting into the bladder, and closing up the communication betwixt the bladder and vagina.

NOTE 37, p. 65. In a case related by Sandifort, the suppression of urine was always attended with convulsive cough. *Lib. I. c. 3.* And in a case related by Dr J. Hamilton, where prolapsus took place before parturition, the muscles of the body were spasmodically agitated. Cases, &c. case 9.

NOTE 38, p. 66. Mr Sharp mentions a case, where they grew in small



quantity upon the orifice, producing excruciating torment till they were extirpated. *Critical Inq.* p. 168.

NOTE 39, p. 66. In the instance related by Mr Warner, the urine was voided in drops with great pain, especially about the menstrual period, and she sometimes even had convulsions. He dilated the urethra, by inclining the catheter to one side, and thus saw two excrescences near the upper end. He divided or laid open the urethra, and cut off the excrescences successfully with scissors. *Cases* p. 309.

NOTE 40, p. 66. In the patient of Mr Hughes, the disease was taken at first for prolapsus uteri, for there was a substance filling the os externum, and appearing without the vulva. It was a spongy excrescence from the whole circumference of the meatus. It was drawn out with a thread passed through it, and then cut off. Strangury, with pain above the pubis, and fever, took place, on which account the catheter was introduced. Suppression of urine repeatedly occurred; and as it was often difficult to introduce the catheter, the semieupium was employed, and always with advantage; but once after it, she became faint, and the limbs were convulsed. A stricture being suspected at the upper part of the urethra, a bougie was introduced, and kept in the canal, which removed the symptoms. *Med. Fact. and Obs.* Vol. III. p. 26.

NOTE 41, p. 66. In Mr. Jenner's case, the irritation of the bladder was great, and the menses were irregular. A fungus was found filling the orifice of the urethra; this was cut off, and the bougie used for an hour every day for a fortnight; a little before the extirpation, a hemorrhage took place from the excrescences. *Vide Lond. Med. Journal*, Vol. VII. p. 160.

NOTE 42, p. 66. M. Sernin relates a case of a girl eleven years of age, who from her fifth year had been subject to frequent attacks of difficulty in voiding the urine. He had an opportunity of examining her after a violent attack, and found a cylindrical body, 4 inches long, projecting from the vulva; and whenever she attempted to make water, this projection swelled up. It was amputated with success. *Recueil Period.* tom. XVII. p. 304.

NOTE 43, p. 66. In Dr Chamberlain's patient, who had the hymen imperforated, the urethra was so dilated as to admit the finger; and Portal found it, in an analogous case, dilated so as to form a cul-de-sac, admitting the point of the thumb. *Cours d'Anat. Medicale*, Tom. III. p. 476.

NOTE 44, p. 67. Morgagni mentions a porter's wife, in whom the uterus was found not above an inch long, and without any ovaria. The pudendum was extremely small, and there was scarcely any appearance of a clitoris. In the *Phil. Trans.* for 1805, there is a case where the uterus of a woman, 29 years of age, was not larger than in the foetal state, and scarcely any appearance of ovaria. She ceased to grow at ten years of age, had no hair on the pubis, never menstruated, and had an aversion to men. I have seen the uterus of the adult not larger than that of a child; the woman never menstruated, and had very flat breasts.

NOTE 45, p. 67. Columbus dissected a woman who always complained of great pain in coitu. The vagina was very short, and had no uterus at its termination.

Fromondus relates an instance, where the place of the os externum was occupied with a cartilaginous substance.

Morgagni was consulted by a barren woman, whose vagina was only a third part of the usual length, and its termination felt firm and fleshy. He advised a dissolution of the marriage.

M. Meyer in Schmucker's Essays, mentions a case where the vagina and uterus were wanting, but the ovaria existed. The labia and clitoris were small, and there were no nymphæ. Mr Ford dissected a child who had no vagina, uterus, or ovaria. The urethra and rectum terminated close to each other. Med. Facts, Vol. V. p. 92.

NOTE 46, p. 67. Vide Hist. de l'Acad. de Sciences, 1705, p. 47.—Haller Opusc. path. 60. Acrell's cases.—Furcel in Phil. Trans. LXIV. p. 474.—Canestrini in Med. Facts, Vol. III. p. 171.—Valisneri met with a double uterus and double vulva. Opera, Tom. III. p. 338.—Dr Pole describes a double uterus in the 4th Vol. of Mem. of Medical Society, p. 92.

NOTE 47, p. 67. Littre found it almost closed, by a continuation of the inner surface of the vagina, Mem. de l'Acad. de Sciences, 1704, p. 27; and in the seventh month of pregnancy, closed by a glandular substance. 1705, p. 2.—Morgagni found it shut with a membrane. Epist. XLVI. art. 17.—Boehmer quite shut up. Obs. Anat. fasc. 2, p. 62.—Ruysch saw it so small as scarcely to admit a pin; and Sandifort so well closed, that nothing but air could be forced through it. Obs. Anat. Path. lib. II. c. ii. p. 67.

NOTE 48, p. 71. Vide Stalpart Vander Wiel, obs. 87.—Segerus in Mis. Cur. 1671, obs. 121. Notwithstanding these cancerous excrescences about the os uteri, a woman may conceive. Dr Denman relates a case where there was a large excrescence in the gravid state, with profuse bleeding. The head of the child was lessened, but the woman died undelivered. Vol. II. p. 65. When the os uteri has been affected with scirrhus, and the woman has conceived, the uterus has sometimes been ruptured, or the woman died undelivered. Hildanus, cent. 1. obs. 67. Horstius Opera, Tom. II. lib. 2. obs. 5. Blancard Anat. p. 233. Hist. de l'Acad. de Sciences, 1705, p. 52.

NOTE 49, p. 71. Le Dran attended a patient who had all the symptoms of scirrhus uterus, and, by examination, fungous excrescences were found shooting down into the vagina. The pain was continual, and could only be mitigated by the constant use of opium. Urine was discharged by the vagina, and after death the bladder was found to be perforated. The fundus and body of the uterus were not much diseased. In some instances the tumor occupies the pelvis pretty firmly, adhering to the sides and neighbouring parts, so that it cannot be raised up, and may press so much on the uterus as to prevent the patient from having a stool, unless by the operation of strong purgatives or clysters.

NOTE 50, p. 72. Absolute abstinence has been recommended by Pouteau, Œuvres Post. Tom. I. p. 105. He relates a case, which was cured by confining the patient to *cau de glace*.—Mr Pearson, p. 113. gives two successful cases. In the first, the uterus was enlarged and retroverted, but by very spare diet, was restored to its natural state.

NOTE 51, p. 74. Vide Mem. de l'Acad. de Chirurg. Licetaud relates a case of a woman who had a tumid belly, and complained of great pain. The womb was not much larger than usual, but it was almost bony. Hist. Anat. Med. p.

320.—Grandchamp found an osseous tumor, as large as the fist, inclosed in a sac, betwixt the uterus and bladder. It produced constant ischuria, relieved only by lying on the back. *Med. and Phys. Journal*, Vol. III. p. 587.

NOTE 52, p. 76.—Gaubius relates a case, where it was complicated with prolapsus uteri. After a length of time, severe pains came on, and in an hour a large stone was expelled; next day a larger stone presented, but could not be brought away until the os uteri was dilated. From time to time after this, small stones were expelled; but at last she got completely well.

NOTE 53, p. 77. In a case which occurred to the late Mr Hamilton of this place, the polypus was expelled by labour pains, but the woman died exhausted.—In a case related by Vater, it was expelled when the woman was at stool. Haller, *Disp. Chir. Tom. III. p. 621.* See also a case in the same work, p. 641. by Schunkius.—In the patient of Vacoussain, the polypus was expelled after severe pain; its pedicle was felt to pulsate very strongly, but a ligature being applied, the tumor was cut off. Instantly the ligature disappeared, being drawn up within the pelvis, but on the third day it dropped off. *Mém. de l'Acad. de Chir. Tom. III. p. 533.*

NOTE 54, p. 77. Vide case by Vater, in Haller, *Disput. Chir. Tom. III. p. 621.*—In the case furnished by M. Espagnet, an attempt was made to introduce the catheter; but a straight one being employed instead of a curved one, or an elastic catheter, it was found necessary previously to make an incision in the fore part of the polypus, which had protruded. *Mém. de l'Acad. de Chir. Tom. III. p. 531.*

NOTE 55, p. 80. Dr Denham, Vol. I. p. 94. mentions a young lady who had suffered long from uterine hemorrhage. A polypus was found just to have cleared the os uteri; a ligature was applied, but as she felt severe pain, and vomited, it was slackened. Every attempt to renew the ligature had the same effect. In six weeks she died, and it was found that the uterus was inverted.

NOTE 56, p. 80. M. Herbiniaux, Tom. II. obs. 17. relates a case. The ligature seemed to act on an inverted portion of the womb, producing pain, fever, and convulsions; it was slackened, but afterwards, notwithstanding a renewal of dreadful suffering, it was, with a perseverance hardly to be commended, employed so as at least to remove the polypus.—Desault found, after having applied a ligature round a polypus, and cut the tumor off next day, that part of the fundus uteri was attached to the amputated substance; the patient did well.—Baudeloeque supposes that some cases, related as examples of amputation of inverted uteri, were merely polypi, accompanied with inversion. *Recueil Period. Tom. IV. p. 115.*

NOTE 57, p. 81. Dr Denman, Vol. I. p. 95, relates a case of polypus with broad stem, which was supposed to be a cancer of the uterus. The ligature was applied, and in eight or nine days it came away; but when the polypus was removed, another substance, nearly of the same size, was found to have grown into the vagina. The woman died in a month. I have seen the common polypus combined with an indurated thickening of the uterus, and fungous or floeculent state of the cavity. In one case of this kind, the uterus and rectum freely communicated by ulceration.



NOTE 58. p. 81. Sometimes the mass appears to be putrid, and is expelled with great hemorrhage. Vide case by Dr Blackbourn, Lond. Med. Journal, Vol. II. p. 122.—Sometimes it has a kind of ossaceous covering, as in the case by Hankoph, in Haller, Disp. Med. IV. p. 715.

NOTE 59. p. 83.—In the Hist. of Acad. of Sciences for 1714, is the case of a woman who received a fall in the third month of pregnancy. The belly, however, increased in size till the fifth, when it began to lessen. In the sixth she was delivered of a bag, as large as the fist, with a placenta and fœtus of the size of a kidney bean. In this case, hydatids were not formed; but in the History for 1715, is a case, where the woman, falling in the second month had the ovum converted into hydatids, which were expelled in the tenth month. As hydatids often succeed to genuine pregnancy, the symptoms may at first be exactly the same with those of pregnancy, nay, even motion may be felt, but afterwards the child may die, and hydatids form.—Mr Watson in the Phil. Trans. Vol. XLI. p. 711, gives a case, where there was, for a long time before the expulsion of hydatids, a quantity of blood discharged every night; pains at last came on, and expelled many hydatids. In this case, the symptoms of pregnancy were evident from Nov. to Feb. When the ovum is blighted, the belly ceases to enlarge in the due proportion, and the breasts become flaccid.

Dr Denman gives an engraving of a diseased ovum: and Mr Home relates a case, where the patient, after being attacked with flooding, vomiting, and spasm in the abdomen, died. On opening her, the womb was found filled with hydatids, and its mouth a little dilated. Trans. of a Society, &c. Vol. II. p. 300.—Such cases as I have seen have been attended with a considerable discharge; but as a great part of it was watery, it made a greater appearance than the real quantity of blood would have caused.

In a case related by Valleriola, p. 71, the woman had at first the usual symptoms of pregnancy, but in the eighth month expelled hydatids.—Pichart in Zod. Med. Gall. an. 3, p. 73, relates a similar case, but the hydatids were expelled in the fourth month without hemorrhage. Other cases of hydatids are to be found in Tulpius, lib. III. c. 32. Shenkius, p. 685. Mereatus de Mullier. affect, lib. III. c. 8. Christ. a Veiga Art. Med. lib. III. §. 10, c. 13, relates an instance of 60 hydatids, as large as chesnuts, being expelled.

Stalpart Vandier-Wiel, Tom. I. p. 301. mentions a woman, who in the ninth month, after enduring pains for three days, expelled many hydatids, and the process was followed by lochia. Lossius, Obs. Med. lib. IV. ob. 16, mentions a widow who for several years had a tumid belly: after death, hydatids were found in utero. See also Mauriecau's Observations, obs. 367. Ruysch, Obs. Anat. Chir. p. 25. Albinus Anat. Acad. lib. I. p. 69. and tab. III. fig. 1. describes in an abortion, the commencement of this change. The vesicles are not larger than the heads of pins. Wrisberg describes a more advanced stage in Nov. Comment. Gotting. Tom. IV. p. 73; and Sandifort, in his Obs. Anat. Path. lib. II. c. 3. tab. VI. fig. 5. has a case extremely distinct. See also Haller, Opusc. Path. ob. 48.

Vigarous, Malad. &c. Tom. I. p. 385, proposes mercury to kill the hydatids. He knew an instance where the woman discharged hydatids always

when she went *a la garde-robe*. Mr Mills relates a case, where the woman betwixt the second and third month, had symptoms of abortion, and afterwards, in the fifth or sixth, expelled above three pints of hydatids. Vide Med. and Phys. Journal, Vol. II. p. 447.

When the mass is expelled, it is found either to consist entirely of small vesicles, or partly of vesicles, and partly of more solid remains of the ovum, or coagulum of blood.

NOTE 60. p. 84. Hildanus relates a case of this kind in his own wife, *dulcissima et charissima conjux mea*. Hydatids may also be combined with pregnancy. The same author tells us of a woman, who, in the fifth month, was delivered of a mola aquosa, or vesicles containing ten pounds of water; she did not miscary, but went to the full time.

NOTE 61. p. 85. Kirkringius, p. 28. considers dropsy of the uterus as impossible, and says, that every case of collection of water depends on a large hydatid. Dr Denman seems to be much of the same opinion. But we find instances where water is accumulated and repeatedly discharged, apparently from the removal of a temporary obstruction. Fernelius relates a case, where the woman always before menstruation discharged much water. Path. lib. VI. c. 15. And M. Geoffroy describes a case of repeated discharge. Vide Fourcroy la Med. Eclairé, Tom. II. p. 287. A case is related by Turner, where the external membrane of the uterus was said to be distended with water. The menses were suppressed, and a secretion of whitish fluid took place from the breasts. Phil. Trans. No. 207.

NOTE 62. p. 87. Sometimes the situation of the abdominal viscera is very much altered. In Mr White's case, the liver was found to descend to the lower part of the belly, and the diaphragm was lengthened so as to allow the stomach to reach the umbilical region. Vide Med. Obs. and Inq. Vol. III. p. I. In a complicated case, related by Schlineker, the pylorus hung down to the pubis. Haller, Disp. Med. IV. 419.

NOTE 63. p. 87. This point is very well considered by Verdier, in his paper on Hernia of the Urinary Bladder, in the first Vol. of Mem. de l'Acad. de Chir. See also a paper by M. Tenon, in Mem. de l'Institute, Tom. VI. p. 614. —Mr Paget relates a very interesting case of prolapsus uteri, in which the bladder became retroverted, lying above the uterus. It could not descend before it, or along with it, being filled with a calculus, weighing 27 ounces, and others of a small size. Some parts of the bladder were an inch thick; a catheter could not be introduced. Med. and Phys. Journal, Vol. VI. p. 391.

NOTE 64. p. 87. Ruysch, feeling some hard bodies in the tumor, formed by the protruded parts, cut out 42 calculi from the bladder. M. Tolet extracted fifty, and afterwards cured the woman with a pessary. Duverney met with large calculus in the bladder, with procidentia uteri; and Mr Whyte relates a similar fact. Med. Obs. and Inq. Vol. III. p. 1. See also Deschamps Traité de la Tallie, Tom. IV. p. 158.

Note 65. p. 87. Kerkringius says, *nemo vidit nemo sensit decepti omnes imagine falsa, alios decipiunt; laxitas quædam colli quæ extra pudendum prominat hæc nobis fecit ludibrio*. Opera, p. 48. Vide also Job a Meekren, Observ. Chir. c. 51. Barbette Chirurg. c. 8. Roonhuysen, Obs. Chir. part. I. ob. 2.

Note 66. p. 88. Dr Monro mentions a procidentia uteri, in a very young

girl. It was preceded by bloody discharge. Works, p. 535. Another case is related by Saviard, Obs. 15, in which the prolapsed uterus was mistaken for the male penis; and as Goldsmith's soldier believed they would allow him to be born in no parish, so this girl was in danger of being determined to have no sex:

NOTE 67. p. 89. Morand relates the case of a woman who had foetid discharge from the vagina, accompanied with pain. On examination, fungous excrescences were discovered in the vagina, and amongst these a hard substance, which being extracted, was found to be part of a silver pessary. The vagina contracted at this spot, and thus, though in a disagreeable way, prevented a return of the prolapsus. Pessaries have also ulcerated through to the rectum; and Mr Blair mentions a woman in the Lock Hospital, who had introduced a quadrangular piece of wood into the vagina as a pessary, and which ulcerated thus into the rectum, producing great irritation. Med. and Phys. Journal, Vol. X. p. 491. It is likewise necessary, if the pessary have an opening in it, to observe that the cervix uteri do not get into the opening, and become strangulated.

NOTE 68: p. 90: See Rossuet, Plater, and Platner, Inst. Chir. section 1447. Wedelius de Prociip. Uteri, c. 4. Volkamer, in Miscel. Cur. an. 2. ob. 226. Another case may be seen in Journal de Med. Tom. LXVIII. p. 195. Pare æuvres, p. 970.—Carpus extirpated it with success. Vide Longii Epist. Med. lib. II. epist. 39.—Slevogtius relates a distinct case, where the womb was found in the vagina, as if in a purse: Dissert. 12.—Benevenius says, he saw a woman whose uterus sloughed off. De Mirand. Morb. Causis, cap. 12.—Dr Elmer supposes he has met with a similar case. Med. Phys. Journal, Vol. XVIII. p. 344.—The latest case is related by Laumonier. The patient was long subject to prolapsus uteri, but at last the womb, with the vagina, was forced out so violently, that she thought all her bowels had come out. At the upper part of the tumor there was a strong pulsation. It was extirpated chiefly by ligature. The woman died some years after this, and the womb was found wanting. La Med. Eclairé, par Fourcroy, Tom. IV. p. 33. M. Baudelocque, however, says, that the uterus was only partially extirpated. Vide. Recueil. Period. Tom. V. p. 332.

NOTE 69. p. 90. Harvey relates a case, where the tumor was as large as a man's head, ulcerated, and discharged sanies. It was proposed to extirpate the prolapsed uterus, but the following night a fœtus was expelled, *epithama longitudine*. Opera. p. 558. See also a case by Mr Antrobus, in Med. Museum, Vol. I. p. 227.

NOTE 70. p. 90. Dr Burton had a patient, who in the fourth month of pregnancy fell, and was thereafter seized with suppression of urine. The os uteri was found almost at the orifice of the vagina. He drew off about three quarts of urine, raised up the womb, and introduced a pessary. System, p. 156.

NOTE 71. p. 90. Mr Dray mentions a case where, in the fourth month of pregnancy, the woman was seized with pains, like those indicating abortion, accompanied with suppression of urine. The os uteri was very near the orifice of the vagina. This disease proving fatal, the bladder was found to be



thickened, enlarged, and in part mortified. *Vide Med. and Phys. Journal*, Vol. III. p. 456.

NOTE 72. p. 91. Reink mentions a woman who was pregnant of twins. In the fourth month the womb prolapsed, and caused a fatal suppression of urine. The vagina, at the upper part, was corrugated and inverted. Haller, *Disp. Chir.* Tom. III. p. 585.

NOTE 73. p. 92. Sampson, in the *Phil. Trans.* No. 140, describes an ovary filled with hydatids, containing 112 pounds of fluid.—Willi mentions a tailor's wife, whose ovary weighed above 100 pounds, and contained partly hydatids, partly gelatinous fluid. Haller, *Disp. Med.* Tom. IV. p. 447.

NOTE 74. p. 93. In a case detailed by Vater, the patient had symptoms of pregnancy, secreted milk, and even thought she felt motion. The belly continued swelled, and she had bad health for three years and a half, when she died. The abdomen contained much water, and the right ovary was found to be as large as a man's head, containing capsules, filled with purulent looking matter. The uterus was healthy, but prolapsed, and the ureter was distended from pressure. Haller, *Disp. Med.* Tom. IV. p. 401. This was not a case of extra-uterine gestation, for the ovary was divided into cells, and had no appearance of fetus.

NOTE 75. p. 93. In some cases it does not ascend out of the pelvis, or if it do, the inferior part of the tumor sinks again into it. Morgagni relates an instance where the ovary weighed 24 pounds; and the lower part of it filled the pelvis so well, that when it was drawn out, it made a noise like a cupping glass when pulled away from the skin. *Epist.* 39, art. 39.

NOTE 76. p. 93. It may be combined with effusion of water in the abdominal cavity. Dr Bosch's patient had 16 pints of water in the abdomen, and both ovaria were enlarged so as to weigh 102 pounds. This patient complained of great pain and weight in the lower belly, and over the right hip. She was much emaciated, but the menses were regular. When she was tapped, not above two tea-cupfuls of fluid were discharged. *Med. and Phys. Journal*. Vol. VIII. p. 444.—Mr French met with a case of ascitis and dropsy of the ovary. The ovary extended from the pubis to the diaphragm. This patient had voracious appetite. *Mem. of Medical Society*, Vol. I. p. 234.

NOTE 77. p. 93. If only one of the ovaria be enlarged, or if both be affected, but only one much increased, the uterus is often not raised, because the ovary turns on its axis, and the uterus lies below it. In a case with which I was favoured by Dr Cleghorn; both ovaria were greatly tumified, and could be felt on each side of the navel, whilst immediately beneath that, they seemed to be united by a flat hard substance; and when the urine was long retained, a fluctuation could be perceived before that part. Upon dissection, a firm thick substance was found, extending from the pubis to the navel, betwixt the ovaria. This was the uterus and vagina. The uterus itself was lengthened, the cervix was three inches long, and all appearance of os tinæ was destroyed. Her complaints began after being suddenly terrified: first she felt severe pain in the right groin, with weakness of the thigh, and soon afterwards perceived a tumor in the belly, and presently another appeared in the left side. She was tapped 16 times.

NOTE 78. p. 94. In a case noticed by Dr Denman, the labour was obstructed until the ovarium was emptied, by piercing it from the vagina. The woman died six months afterwards. *Introd. Vol. II. p. 74.* In Dr Ford's case, related by Dr Denman, the crotchet was employed. See also a case by M. Baudelocque, *l' Ars des Accouch.* 1964.

NOTE 79. p. 94. Dr Denman justly observes, that diuretics have no effect, *Vol. I. p. 122.* And Dr Hunter remarks, that "the dropsy of the ovarium is an incurable disease, and that the patient will have the best chance for living longest under it, who does the least to get rid of it. The trocar is almost the only palliative." *Med. Obs. and Inqu. Vol. II. p. 41.*

Willi, however, relates a case of 14 years standing, which was cured by diuretics; and it was calculated that the tumor contained 100 pounds of fluid. *Haller, Disp. Med. Tom. IV. p. 451.*

NOTE 80. p. 96. Dr Denman advises the operation to be deferred as long as possible, and I believe he is right; for every operation is followed by re-accumulation, which is a debilitating process; yet it is astonishing how much may in the course of time be secreted, without destroying the patient. Mr Ford tapped his patient 49 times, and drew off 2786 pints. The secretion was at last so rapid, that three pints and three ounces were accumulated daily. *Med. Commun. Vol. II. p. 123.*—Mr Martineau tapped his patient 80 times, and drew off 6631 pints, or 13 hogsheads; at one time he drew off no less than 108 pints. *Phil. Trans. Vol. LXXIV. p. 471.*

NOTE 81, p. 96. Le Dran relates two cases in the *Mem. de l'Acad. de Chir. Tom. III.* In the first, the cyst was opened, and the woman cured of the dropsy, but a fistulous opening remained, p. 431. In the second, he made a pretty large incision, and introduced a canula into the sac. The operation was followed by fever, delirium, and vomiting; the woman retained nothing but a little Spanish wine for three weeks. She discharged daily 8 or 10 ounces of red fluid. At length, all of a sudden, 15 ounces of white pus were evacuated, and then the symptoms abated; but a fistula remained for two years, when it healed, p. 442.

Dr Houston relates the case of a woman in his neighbourhood, in whom he made an incision 2 inches long into the ovarium, and then with a fir splint turned out a great quantity of gelatinous matter and hydatids. He kept the wound open with a tent, and succeeded in curing the patient. The disease was attributed to rash extraction of the placenta, and had existed for 13 years. It was attended with violent pains. *Phil. Trans. XXXIII. p. 5.*

M. Voison relates a case, which was palliated by tapping, and keeping a fistula open. *Recueil Periodique, Tom. XVII. p. 381.* And Portal gives an instance, where, by keeping the canula in the wound for a short time, a radical cure was obtained, and the person afterwards had children. *Cours d'Anat. Tom. V. p. 554.*

NOTE 82, p. 96. De La Porte tapped a woman who had a large tumour in the belly, but nothing came through the canula. He made an incision of considerable length, and, in the course of two hours and an half, extracted 35 lb. of jelly. The lips of the wounds were then brought together. Next day 15 lb. of jelly were evacuated, but presently vomiting and fever took place;

and she died on the thirtieth day, having discharged altogether 67 lb. of fluid. This disease was of sixteen months standing, and was attributed to hemorrhage. *Mem. de l'Acad. de Chir. Tom. III. p. 462.*

Dr Denman notices the case of a patient, who died the sixth day after injecting the ovarium. *Vol. I. p. 122.*

NOTE 83. p. 96. Dr Monro, in *Med. Essays, Vol. V. p. 773*, details the history of a patient who had a diseased ovarium, and in whom the tumour pointed about four inches below the navel. It was opened, but nothing but air came out, followed next day by *stercus*: on the fifth day some pus was discharged. She gradually improved in health, and the tumour of the belly subsided; but in two years afterwards the suppuration was renewed, and she died. In this case, the colon had probably adhered to the ovarium.

NOTE 84. p. 96. Dr Denman relates the case of a patient, who, having for some time suffered from pain and tenderness about the sacrum and uterus, and uterine hemorrhage, was suddenly seized with vomiting, syncope, pains in the belly, and costiveness; presently a tumor was felt in the right side, and this soon occupied the whole abdomen. This patient was cured, after purging a gelatinous fluid. *Med. and Phys. Jour. Vol. II. p. 20.*

NOTE 85. p. 96. Dr Monro relates a case of supposed pregnancy, in the tenth month of which, the tumor was removed by an aqueous discharge from the vagina. In a future attack, however, violent bearing-down pains were excited, and the woman died exhausted. The left ovarium was found greatly enlarged with vesicles. *Med. Essays, Vol. V. p. 770.*

NOTE 86. p. 97. See Dr Baillie's *Morbid Anatomy*, chap. 20. Dr J. Cleghorn mentions a woman who died ten days after being tapped. The right ovarium was found greatly enlarged, and had many cells, some containing hair, cretaceous matter, fragments of bone and teeth, other gelatinous fluid. *Trans. of Royal Irish Acad. Vol. I. p. 80.* In *Essays Phys. and Literary, Vol. II. p. 300*, a case is mentioned, in which the one ovarium contained many vesicles; the other contained a mass, like brain, with bones and teeth. In the Museum attached to the hospital at Vienna, there is a large ovarium, the inner surface of which is covered with hair. Horstius met with an ovarium, containing hair, purulent looking and oily matter. *Opera*, p. 249. Schenkius met with fat and hair, p. 556, and Schacher relates a similar case in *Haller's Disp. Med. Tom. IV. p. 477*. Ruysch, in his *Adversaria*, says, he met with bones and hair, and Le Rich, in the *Hist. de l'Acad. de Sciences*, 1743, met with hair and oil, in cells, together with bones and teeth. See also *Recueil Period. Tom. XVII. p. 462.*

NOTE 87. p. 97. Duverney saw a tumor extirpated from the scrotum, containing fleshy matter and bones. *Œuvres, Tom. II. p. 562.* And M. Dupuytren presented a report to the Medical School at Paris, relating the history of a tumour found in the abdomen of a boy, containing a mass of hair, and a fetus nearly ossified. It was supposed, that at conception, one germ had got within another. See *Edin. Med. Jour. Vol. I. p. 376.* From the respectable evidence of Baudelocque, Le Roy, &c. this cannot be placed on a footing with Halley's case of a greyhound dog, who voided by the anus a living whelp.



Phil. Trans. Vol. XIX. p. 316. I believe that bones, hair, &c. have been found in a gelding.

NOTE 88. p. 97. Schlencker mentions a woman, who, soon after delivery, felt obtuse pains in the left side, and presently a swelling appeared in the belly. She had bad appetite, swelled feet, prolapsed uterus, and suppression of urine and feces. The left ovary was hard and stony, and weighed 3 ounces. Haller, Disp. Med. Tom. IV. p. 419. In this case the tumefaction of the belly could not be caused by the presence of the ovary, but rather by the pressure on the intestines.

NOTE 89. p. 97. Vide case by Fontaine, in Haller, Disp. Med. Tom. IV. p. 485. The patient had tumor of the abdomen, with lancing pains in the left side, extending to the thigh. The left ovary weighed 10 pounds, the right was as large as the fist, and both consisted of fatty matter. Portal likewise relates a case of this disease, where the right ovary was as large as a man's head, very hard, and filled with steatomatous matter, weighing altogether 35 pounds. The uterus and bladder were turned to the left side. No water was effused, but the person was cut off by hectic and diarrhoea. Some steatomatous concretions were found in the lungs. Cours d'Anatomie, Tom. V. p. 549.

## CHAP. XII.

NOTE 1. § 1. p. 106. Although hysteria be not a diseased state of menstruation, yet, as it is a very general attendant upon deviations of that action, and a very frequent and distressing complaint, to which women are subject, it will be proper to notice it briefly at this time.

In the well marked hysteric paroxysm, a sense of pain or fulness is felt in some part of the abdomen, most frequently about the umbilical region, or in the left side, betwixt that and the stomach. This gradually spreads, and the sensation of a ball is felt passing along. It mounts upwards, and by degrees reaches the throat, and impedes respiration, so as to give the feeling of a globe in the œsophagus, obstructing the passage of the air, and, as Van Swieten observes, the throat appears sometimes really to be distended. The patient now falls down convulsed, and apparently much distressed in breathing, uttering occasionally shrieks, something like the crowing of a cock, or sobbing violently, or otherwise indicating a spasm of the muscles of respiration. She is generally pale, and frequently insensible, at least during part of the fit, and seems to be in a faint; but when she recovers, she is conscious not only of having been ill, but of many things which passed in a state of apparent insensibility. After remaining for some time in a state of considerable agitation of the muscular organs, the affection abates, and the patient remains languid and feeble, but gradually recovers, and presently is restored to her usual health. This restoration is accompanied with eructation, which indeed often takes place during the paroxysm; and also by the discharge of limpid urine, which, by Sydenham, is considered as a pathognomonic symptom of hysteria. Headach is also apt to follow a fit.

Besides producing these regular paroxysms, hysteria still more frequently occasions many distressing sensations, which are so various, as not to admit of description. Of this kind are violent headach, affecting only a small part of the head, sudden spasms of the bowels, dyspnœa, with or without an appearance of croup, and sometimes attended with a barking cough, irregular chills, and sudden flushings of heat, spasmodic pains, palpitation, syncope, &c. These, if severe, or frequently repeated, are generally attended with a timid or desponding state of mind.

During an hysterie fit, the patient is to be laid in an easy posture, a free admission of cool air is to be procured, the face is to be sprinkled with cold vinegar or Hungary water, volatile salts are to be held to the nostrils, and if she can swallow, 30 drops of tincture of opium are to be administered, with the same or a greater quantity of ether, in some carminative water; or should there be a tendency to syncope, a dram of the spiritus ammoniæ aromaticus may be conjoined.

A similar combination of opium is the most powerful remedy in the different hysterical affections above enumerated. But it is further useful to remark, 1st, that local pain is frequently removed by sinapisms, with or without the internal use of opium; 2d, that severe affections of the organs of respiration sometimes yield more speedily to emetics than to antispasmodics, or may even require the use of the lancet, but this mode of evacuation is to be avoided as much as possible, as it increases a disposition to the disease; 3d, that irregular action of the heart, besides requiring powerful antispasmodics, demands, more than any other symptom, during the attack, a state of rest, and the removal of every thing which can agitate the mind; 4th, continued insensibility, or coma, is a very dangerous symptom, as it may end fatally; the lancet ought to be early, but not largely used, the bowels should be emptied, and the head covered with a blister.

The prevention of regular hysterie fits, or of individual symptoms, is to be attempted by a tonic plan, especially by the use of the cold bath, moderate exercise, preserving a *correct* state of the bowels, or even giving pretty powerful purges, and the administration of preparations of steel: the mind ought also to be called as much as possible from brooding over the disease; for in hysteria, the patient is frequently desponding, and anticipating many evils. The menstrual action, if irregular, must, if possible, be rectified by appropriate remedies. The diet should be light, and rather sparing, and all causes of debility must be avoided.

If particular symptoms should be frequently repeated, or the fits occur often, it may be useful to conjoin along with this plan, the exhibition of some antispasmodic medicine, such as valerian, asafetida, or camphor.

Hysteria may occur during the course of other diseases, or in the stage of convalescence from them. In the first case, it may cause some deviation from the regular progress or train of symptoms of the disease, and, it is to be feared sometimes calls the attention of the practitioner from more serious parts of the patient's malady.

## CHAP XV.

NOTE 1. p. 131. In the eggs of fowls, we observe the following circumstances. 1st, Upon removing the porous shell, we find the albumen inclosed in a membrane, consisting of two layers, and called sacciform by Leviellé. These are separated from each other at the large end of the shell, so as to form a small sac, called the folliculus aeris. The albumen is divided into three strata; the first, or cortical, is most liquid; the second, or middle, is more abundant, and thicker than the first, but less so than the third or central. The middle and central strata are inclosed in a delicate membrane, called leucilyme by Leviellé, which separates them from the cortical. 2d, Within the albumen we have the vitellus or yolk, which is inclosed in a vascular membrane, called chlorilyme, or membrana vitelli, which again is enveloped by a membrane common to it and the intestines of the chick, called entro-chlorilyme. 3d, To each end of the vitellus, we have connected a portion of the central albumen, called chalaza; and in each of these a membranous substance is discovered, attached to the membrane of the vitellus, and a vascular structure, which can absorb the albumen into the vitellus, to contribute to the nutrition of the chick. 4th, Upon the vitellus, we observe the cicatricula, or small sac, called by Harvey the eye of the egg, and which was supposed to contain the fœtus, the rudiments of which are allowed by Malpighi, Haller, and Spallanzani, to be pre-existent to fecundation. This cicatricula was considered as analogous to the amnion, and supposed to contain a transparent fluid, called by Harvey colliquamentum candidum, or liquor amnii. More modern observations ascertain that the embryo is not formed in the cicatricula, but very near it on the vitellus, and that the amnion inclosing it, can at first scarcely be distinguished from the embryo. The cicatricula soon disappears. Harvey's account must therefore be transferred to amnion. 5th, During incubation, the vitellus becomes specifically lighter than the albumen, and rises toward the folliculus aeris. Two arteries and two veins go from the mesenteric and hypogastric vessels of the fœtus, to the membrane of the yolk, and are supposed to absorb the vitellus, which therefore is carried to the vena portæ of the chick, and nourishes the fœtus. There is also a connection betwixt the intestines and vitelline membrane, by means of a ligamentous substance, which was supposed by Haller and Vicq. D'azyr to be a tube, and called vitello-intestinal canal, for it is said that air has been passed through it. It was supposed to absorb the yolk, by many villi on the inner surface of the vitelline membrane; but these are said by Leviellé not to be vessels, but soft lamellated plates. At the end of the second day, red blood is observed on the membrana vitelli. A series of dots are formed, which are converted first into grooves, and then into vessels, which go to the fœtus. This appearance has been called figura venosa, and the marginal vessel vena terminalis. 6th, The vitello-intestinal ligament, and these vessels, form an umbilical cord. But besides these, we find, after the fourth day, a vascular membrane at the umbilicus, called membrana umbilicalis, which rapidly increases, and comes presently to cover the inner surface of the membrane of the shell. It is the chorion, and has numerous vessels ramifying on



It, like the chorion of the sow, and connected in like manner with the fœtus. The blood of the umbilical artery is dark coloured, that of the vein bright. 7th, As incubation advances, the amnion enlarges, and comes in contact every where with the chorion. The albumen is all consumed, being taken into the vitellus, which is in a great measure absorbed; and what remains is taken, together with the sac, into the abdomen of the chick, and the parietes close over it. On the 21st day, the chick breaks the shell and escapes. By increasing or diminishing the temperature within a certain extent, the process may be somewhat accelerated or retarded. The eggs of large birds require a longer time to be hatched; those of the ostrich, for example, take six weeks.

Hence it appears, that the vitellus and albumen contribute to the increment of the fœtus, whilst the exterior membranes acts as lungs, the air being transmitted through the pores of the shell.

The eggs of fishes have a general resemblance to those of fowls, and consist of a vitellus and albumen, with their membranes; but in place of being furnished with a shell, they have a tough, or sometimes a horny covering, and some, as those of the shark, torpedo, &c. are quadrangular in shape. The yolk is connected to the intestines of the fœtus, and its membrane is very vascular. As in fowls, so in fishes, it is ultimately inclosed within the abdomen of the young. In the skate, numerous blood vessels are formed in the albumen, which supply the place of gills, and are supposed by Dr Monro, to be afterwards covered and converted into gills. The two functions of a placenta, then, are still more distinctly fulfilled here than even in fowls, for the apparatus for nutrition and respiration has different or distinct terminations; whereas in fowls and quadrupeds, all the vessels enter at one place. A similar fact is observed in the ova of frogs, for the umbilical cord in the tadpole goes to the head.

The egg of the serpent is nearly the same with that of the fish, and is inclosed in a flexible membrane. The fœtus is coiled up spirally within it, and the chorion is vascular, as in the egg of the fowl.

The adder is a viviparous animal; its uterus is membranous, and divided, I find, into eight or nine cells, each of which, in September, contains an ovum as large as a chesnut. This consists of an exterior membrane, which incloses a fœtus about six inches long, and coiled up. About an inch from the tail, the umbilical cord passes out, which consists of vessels that go to ramify on the exterior membrane, which resembles the chorion of the sow. There is also a connection with a vitellus, which is as large as a hazel nut.

The coluber natrix is said, by Valmont-Bomare, to have a placenta and cord within the egg, but this is contrary to the general structure of eggs; most likely the chorion has been taken for the placenta. The eggs of reptiles are often deposited in packets, the eggs being glued together.

The egg of the turtle is as large as a hen's, and is inclosed in a covering like parchment. It is deposited in the sand, and is hatched in about 24 days. The egg of the alligator is similar in structure to that of the turtle; it is rather larger than a goose's egg, and covered with a thin skin, so transparent, however, that the fœtus may be seen through it.

Those animals which are called oviparous hatch their eggs out of the body either by sitting on them as we see in fowls, or by exposing them to the heat

of the sun, as the turtle, crocodile, and many serpents. Oviparous fishes, which comprehend all those called osseous, expel their ova into the water, where they are fecundated by the male, but without copulation. Many fishes leave the sea, and come up the rivers to spawn. Others remain in the ocean; and the eggs, specifically lighter than the water, float on the surface. Many fishes attach them to marine plants, and in some cases the ova are fixed to the body of the parent. The ova are covered with a kind of mucus, which has been supposed to defend them from the water.

The ova of frogs, &c. are likewise fecundated and hatched out of the body. They are enveloped in a glary matter, which perhaps contributes to their increase; for during incubation, the egg both enlarges and changes its shape.

Those animals which hatch their eggs within the body are called ovo-viviparous, such as cartilaginous fishes, as the shark, skate, and torpedo, &c. The scorpion and venomous serpents also belong to this class. Ovo-viviparous animals expel the young fully formed, and therefore have been sometimes considered as having uteri like quadrupeds, and a cord attached directly to it. Spallanzani at first supposed that the fœtus of the torpedo was attached directly to the uterus, but afterwards found that it was contained in a distinct ovum. Experiences, p. 294. See also Cuvier *Leçons d'Anat. Comparée*, Tom. V. p. 142. The shark is said to have an uterus like the bitch, and Belon says he saw a female delivered of eleven young, attached by a cord. Its mode of gestation most likely is similar to the torpedo. This class expel their young often very quickly. A female *syngnatus hypocampus* was observed to expel at least a hundred in a very short time.

Analogous to ovo-viviparous animals, are those which receive the ova into cells on the surface of the body, where they are hatched. This is well seen in the pipa, a species of toad. Even the tadpoles are said to be metamorphosed in these cells. The opossum tribe has a modification of this gestation; for in them the fœtus, when very small, is expelled into a bag situated on the belly, and immediately attaches itself to a nipple. The utero-gestation of the opossum of North America lasts only from 20 to 26 days, and the embryo when expelled does not exceed a grain. It remains in the sac about 50 days, and acquires the size of a mouse. In other animals, as for instance the bat, the young after birth attach themselves to the nipple, partly for the convenience of being transported or carried about.

In plants, we find likewise a placenta or structure, intended for the nourishment and respiration of the fœtus. To take the kidney bean for an example, we find within the membranous covering two parenchymatous lobes, or cotyledons; and at the margin betwixt these, there is the corculum or epicotyle. During incubation, we find that this sends up a small shoot called the plumula, and down a radical into the earth. But to support the plant until the root and leaves are capable of maintaining it, we find the cotyledons rise up out of the earth, on each side of the plumula, forming what are called seed leaves. These both serve for the respiratory organs, and also supply pabulum, which is absorbed by proper vessels, and in consequence thereof they presently are destroyed. When there are more lobes than two in the seed, there are a corresponding number of seed leaves. In many cases these cotyledons do not rise

out of the ground, but the plumula alone appears. This is the case with the garden pea, but the cotyledons still perform their functions below the ground, and exist until the foliage of the plant, or adult organs, be formed. The greatest part, then, of a vegetable seed or ovum, consists, like the eggs of fowls, of an apparatus intended for the nutriment and respiration of the fœtus, whilst the embryo itself is very small. The cotyledons consist, in many cases, of a farinaceous substance. In other seeds it is oily and farinaceous, and in some it is almost all oily.

Vegetable ova sometimes are contained in a dry pericarpium, and are shed into the earth when it bursts. But others have an apparatus provided, not only for their present growth, but also for accelerating their incubation in the earth. In stone fruit and nuts, we find that vessels pierce the shell at the bottom, and pass on toward the top, and reach the kernal or lobes, which are contained within the shell, enveloped in a soft membrane. They are inserted very near the embryo. Now, for the farther support of these parts, we find that stone fruits are covered with a quantity of nutritious matter. The almond, for example, has its ligneous nut covered with a fleshy substance about an inch thick, inclosed in a proper membrane. The rhamnus lotus has the stone surrounded with farinaceous matter, which tastes like gingerbread. Other seeds are contained in a parenchymatous or succulent substance, as the apple or pear, or in a firm white substance like cream or marrow, or in a mucilaginous matter as the gooseberry, or in an organized pulp as the orange and garcinia mangostona. Some are deposited in a luscious fluid at first, which ultimately becomes farinaceous, as the plantain.

## CHAP. XVII.

NOTE 1. p. 138. In Dr Clark's case the morning sickness; and other signs of pregnancy, appeared very regularly. At the end of nine months, attempts were made to expel the fœtus. These were followed by inflammation and decline of health. Then suppuration took place, and the patient sunk. Transactions of a Society, &c. Vol. II. p. 1. In Mr Mainwaring's case, in the same work, p. 287, the patient suffered much from morning sickness, and pain at the groins.

NOTE 2. p. 138. In the Journal de Sçavans for 1756, we are told of a woman at Louvain, who at first had so dreadful pain when she went to stool, that she thought her bowels were coming out.—In Pouteau's case, the woman suffered great pain till after the second month. *Mélanges*, p. 333.

NOTE 3. p. 138. Bianchi mentions a case, in which, in the first months, the woman complained of great pain in the lower belly, with nausea and fainting fits. The motion of the child ceased in the fifth month, and then milk was secreted. *De Nat. in Hum Corp. Vitioso Morbosaque Gener.* p. 166.—In Dr Mounsey's case, the pain, vomiting, and fainting fits, continued till the woman quickened. *Phil. Trans.* Vol. XLV. p. 131.—In Dr Fern's case, the person complained of great pain till the third month; and from that period till the 8th



month, was subject to convulsions and syncope. Phil. Trans. Vol. XXI. p. 121.

NOTE 4. p. 138. In Dr Perfect's case, no labour pains came on, but the motion of the child ceased at the end of nine months. The abdomen neither increased nor diminished in size for two years and seven weeks; but she was afflicted with constant pains in the hypogastric region, attended with fever, and finally sunk under marasmus. Cases in Midwifery, Vol. II. p. 164.

NOTE 4. p. 139. In a case of a French mulatto woman, which ultimately terminated fatally, the outlines of which I was favoured with by Dr Chisholm, the pain was so great, that it could not be allayed by the strongest opiates.

NOTE 5. p. 139. Vide cases by Longius, in his *Epistolæ*, Tom II. p. 670. Tulpus Opera, lib. IV. c. 39. p. 358.—Pouteau in his *Mélanges*, p. 373.—Mr Shiever, in Phil. Trans. No. 303. p. 172.—Winthrop, Phil. Trans. Vol. XLIII. p. 304, and Simon, p. 529.—Lindestaple, Vol. XLIV. p. 617. Morley, Vol. XIX. p. 486. Gordon, in Med. Comment Vol. XVIII. p. 323. Cammel, in Lond. Med. Jour. Vol. V. p. 96. Case by M. Bergeret, in the *Recueil Periodique*, Tom. XIV. p. 289.

NOTE 6. p. 139. Vide Marcel. Donatus, De Med. Hist. Mirab. lib. IV. c. 22.—Horstii Opera, Tom. II. p. 536. In this case, the fœtus was discharged both by the vagina and rectum.—Benevoli, in his *Dissert.* p. 104, gives an instance where the greater part of the child was expelled by the vagina, but the woman died before the process was completed.—Mr Smith's case, in Med. Comment. Vol. V. p. 314.—In Mr Colman's case, pains came on, and the head was felt in the pelvis at the time of her reckoning, and long afterwards, but the os uteri could not be perceived. In some time, hectic fever, with diarrhœa and sore mouth, appeared. Six months after her attempts at labour, an opening was felt in the vagina, but very unlike the os uteri. The hand was introduced, and a putrid child was extracted. Some fœces continued to come by the wound, but at last, she got well. Med. and Phys. Jour. Vol. II. p. 262.—See also Camper's case, in his *Demonst. Anat. Path.* lib. II. p. 16; and Dr Fothergill's case, in Mem. of Med. Society, Vol. VI. p. 107.

NOTE 7. p. 139. Vide Stalpart Van der Wiel Opera, Tom. I. p. 305. In this case, bones came away with the urine.—In the case of Ronseus, the child was discharged partly by the bladder, but chiefly by the anus. *Epist. Med.*—A similar instance is related by Morlanne, the extraneous matter forming a nucleus for a calculus. *Recueil Period.* Tom. XIII. p. 70.—In Prof. Josephi's case, the child was found altogether in the bladder. Med. and Phys. Jour. Vol. XIV. p. 519.

NOTE 8. p. 139. Vide case of Mrs Stag, in Lond. Med. Obs. and Inquiries Vol. II. p. 369; and cases by Mr Jacob, Dr Maclarty, and others.

NOTE 9. p. 139. In Mr Gifford's case, the child was expelled entire by the anus, and even the cord was found hanging out of the intestine. Phil. Trans. Vol. XXXVI. p. 435.—See also Mr Goodsir's case in *Annals of Medicine*, Vol. VII. p. 412.

NOTE 10. p. 139. In Dr McKnight's case, although the cæsarean operation was performed before any had effects were produced on the health, no part of the placenta could be found.

NOTE 11. p. 139. In Dr Clark's case, the tube burst in the second month, and the woman died from loss of blood. *Transactions of a Society*, Vol. I. p. 216.—Vide case by Duvervey, in his works, Tom. II. p. 353 : and by M. Littre in the *Memoirs of the Acad. of Sciences*, for 1702, and by Riolan, in his works. See also *Med. Comment.* Vol. I. p. 429.—In Mr T. Blizard's case, rupture took place at a very early period, for the woman had miscarried only five weeks previous to this event. *Vide Edin. Phil. Trans.* Vol. V. p. 189.

NOTE 12. p. 139. I have known the fœtus retained for twenty years ; and there are some instances, where it has been retained thirty, forty, or fifty years. Mrs Ruff, whose case is related in the *Med. and Phys. Jour.* for May 1800, carried the child fifty years. Middleton's patient carried it sixteen years. *Phil. Trans.* Vol. XLIV. p. 617: Mounsay's thirteen years, Vol. XLV. p. 121. Steigertahl's forty-six years, Vol. XXXI. p. 126. Broomfield's nine years, Vol. XLI. p. 696. Sir P. Skippon's patient discharged it by suppuration at the groin, after retaining it twenty years, Vol. XXIV. p. 2070. See also cases by M. Grivel, in *Edin. Med. Jour.* Vol. II. p. 19, and Dr Caldwell, p. 22. Sometimes no attempt is made to expel, but the fœtus is converted into a substance, which Foureroy finds to resemble the *gras des emeticieres*. *System*, Tom. X. p. 83. Sandifort relates a case, where, after attempts at labour, no further inconvenience was sustained, but the child was found after twenty-two years to be indurated. *Observationes*, lib. II. p. 36. He quotes Nebel for a case, where it was retained fifty-four years. Cheselden found it converted into earthy matter. The late Mr Hamilton of this place had a preparation of a fœtus, covered with calcareous matter, which was retained 32 years. This woman had pains at the end of nine months, after which the belly decreased in size.

NOTE 13. p. 139. In the 5th Vol. of the *Edin. Med. Essays*, there is related a case, in which the patient seemed to have a second extra-uterine pregnancy before she got quit of the first.—See also Primrose de *Morb. Mul.* p. 326.—Mr Hope, in the 6th Vol. of the *Med. and Phys. Jour.* p. 360, details a case, where the woman in the seventh month of pregnancy had pains, which continued for three weeks, and then went off, leaving a hard tumor on the left side, which was somewhat painful ; she then had another pregnancy, and a fortnight after delivery, began, after taking a laxative, to vomit, and continued to do so, ultimately throwing up feculent matter. The case ended fatally.—See also Turk, in Haller, *Disp. Chir.* IV. 793.

NOTE 14. p. 140. In Mr White's case, related in *Med. Comment.* Vol. XX. p. 254, the symptoms were very like those of retroversion, and the case was only distinguished by the result. In Mr Cammel's case, there was not only a tumor betwixt the vagina and rectum, but the os uteri was turned upward and forward. *Lond. Med. Jour.* Vol. V. p. 96. Mr Kelson's case very much resembled retroversion, for in the tenth week both the urine and stools were obstructed. In about a fortnight, the impediment was suddenly removed, and the uterus felt in situ. She continued well till the ninth month, when labour ineffectually came on ; but in process of time, the child was discharged by the anus. *Med. and Phys. Jour.* Vol. XI. p. 293.

NOTE 15, p. 140. Boehmer long ago observed this ; and Dr Baillie, in

the 79th Vol. of the Phil. Trans. mentions, that Dr Hunter had a preparation of tubal pregnancy, in which the uterus was found enlarged to double its natural size, and containing decidua. He also states, that in an ovarian case, the uterus was enlarged, thick, and spongy, and its vessels enlarged. Dr Clarke found the uterus, in the second month of an extra-uterine pregnancy, exactly of the same size as if the embryo had been lodged within it. The decidua was formed, and the cervix filled with gelatinous matter. Transactions of a Society, Vol. I. p. 216. See also a case by Saviard, in Phil. Trans. No. 222, p. 314. A case, similar to Dr Clarke's is related by Mr T. Blizard, in the Edin. Phil. Trans. Vol. V. p. 189. See also Annals of Med. Vol. III. p. 379.

NOTE 16. p. 140. In Mr Houston's case, the cervix was so closed up that it would not admit a probe. Phil. Trans. Vol. XXXII. p. 387. The decidua would appear sometimes to enlarge, and form a mass like placenta, which in Mr Turnbull's case was expelled with hemorrhage. Mem. of Med. Society, Vol. III. p. 176.

NOTE 17. p. 140. In the case related by Varoequier, the ovarium did not acquire a larger size than an egg. The woman died, after suffering violent pain in the left side, low down. The viscera were slightly inflamed. Mem. de l'Acad. de Sciences, Tom. CXIII. p. 76. In the case by L'Eveille, the fœtus was apparently betwixt three and four months old. Rapport de la Société Philomatique, Tom. I. p. 146. See also a case in the Recueil Period Tom. XIII. p. 63; and in the Recueil des Actes de la Société de Santé de Lyon.

NOTE 18. p. 140. Vide Chambon, Malad. de la Grossesse, Tom. II. p. 373. Case by St Maurice, in Phil. Trans. No. 150, p. 285. In the case related by La Roeque, the ovarium was found ruptured, and the abdomen full of blood. Journ. de Med. 1683. Boehmer found the ovarium ruptured, and the fœtus half expelled. Obs. Anat. fasc. prim. Dr Forrestier's patient, after violent cholic pains, voided blood by the anus. The hemorrhage and fainting fits proved fatal. The fœtus was found in the ovarium. Annals of Medicine, Vol. III. p. 379.

NOTE 19. p. 141. Vide Røderer, Elemens. c. 15, § 758. In Mr Dumas' case, a fluid like chocolate was drawn off by tapping, which was twice performed. The ovarium contained hair, bones, &c. La Med. Eclairée, Tom. IV. p. 65. Mr Bell's tubal case excited ascites.

NOTE 20. p. 141. Vide Dr Kelly's case, in Med. Obs. and Inquiries, Vol. III. p. 44. In Mr Clarke's case, the placenta was attached to the kidneys and intestines. Mem. of Med. Society, Vol. III. p. 197. In the Mem. of the Acad. of Sciences, there is a case related, where the placenta adhered to the lumbar vertebræ. In the history by La Coste, it was placed under the stomach and colon. Vide Œuvres de Duverney, Tom. II. p. 363. In Mr Turnbull's case, it was very thin, and adhered to the intestines. Mem. of Med. Society, Vol. III. p. 176. A case of ventral pregnancy, complicated with hernia, is related by M. Martin in the Recueil des Actes de la Société de Santé de Lyon. Courtial found it adhering to the stomach and colon.

NOTE 21. p. 141. Dr Maclarty relates the case of a negress, where the breech of the child protruded through an ulcer, at the lower part of the abdo-



minal tumor, and the arm at the upper part of the tumor. The intermediate portion of skin was divided, and the fœtus extracted. The head of the child stuck pretty firmly, but was brought out with the forceps. There was no placenta, but putrid matter was discharged with the child. The woman recovered. *Med. Comment.* Vol. XVII. p. 481. Another case is related by Duverney, where the child was extracted from the groin; and this is one of the rare instances where the placenta was not destroyed. It was extracted with the child. *Œuvres*, Tom. II. p. 357. Cyprianus gives an instance of the child being removed, after having been retained twenty-one months. *Histor. Fetus. Hum. Salva. Matre, ex Tuba. Excisi.* Mr Brodie enlarged the navel with a lancet. *Phil. Trans.* Vol. XIX. p. 580. See also M. Baynham's case, in *Med. Facts*, Vol. I. p. 73. In Mr Bell's case an incision four inches in length was made, and the bones of two children extracted. *Med. Comment.* Vol. II. p. 72. Dr Haighton relates an interesting case, where some bones were discharged by the vagina, but the tumor also pointed above the pubis, and through this one of the ribs appeared. The practitioner made an incision, but so great hemorrhage came on, that he was obliged to apply a bandage till next day, when he extracted the bones. The woman recovered. *Med. Records*, p. 260. Dr M'Night performed the operation in the twenty-second month, although the woman enjoyed tolerable health; very dangerous symptoms supervened, but the woman, who certainly was brought into a very hazardous state by the premature operation, did recover. No placenta was found. *Mem. of Med. Society*, Vol. IV. p. 342.

NOTE 22. p. 142. In Dr Morley's case, this happened two years after the original abscess had healed. *Phil. Trans.* Vol. XIX. p. 486. Mr Moyle details a history, where the abscess first of all burst, in consequence of leaping over a hedge. Bones continued to be discharged for a year, without much injury to the health. The abscess then healed, but three years afterwards a tumor again appeared, and, in consequence of exertion, burst; when about a yard of intestine protruded. Some days elapsed before Mr Moyle saw her. The intestine was then gangrenous, but she lived 12 days longer, and the portion was thrown off before death. *Med. Jour.* Vol. VI. p. 52.

NOTE 1. p. 171. Mr Pearson relates a case, where the uterus was retroverted, in consequence of being scirrhus. Vide Pearson on Cancer, p. 113. Dr Marcet gives an instance where the uterus was retroverted, without pregnancy, producing constipation and vomiting. Vide Cooper on Hernia, part II. p. 68.

NOTE 2. p. 172. M. Baudelocque relates a case, where the fundus uteri protruded at the os externum, the patient at the same time having violent inclination to expel something. He was, however, able speedily to reduce the womb to the proper state. Vide l'Art, &c. § 251. In Dr Bell's case, a portion of the rectum was protruded by the uterus. *Med. Facts*, Vol. VIII. p. 32.

NOTE 3. p. 172. M. Baudelocque gives a case of this kind, § 253. In Dr Bell's case, as the woman complained for five weeks of dysuria only, it is likely, that for that period the retroversion was not complete. *Med. Facts*, Vol. VIII.

p. 32. Dr Hunter supposed that it might take place in various degrees ; it might be complete, or semi-complete, or even the os uteri might remain in its natural situation. He says, that Dr Combe and he saw a case, where the os uteri was pushing out as in a procidentia ; but this, perhaps, will not be admitted to have been retroversion. *Med. Obs. and Inq.* Vol. V. p. 388. In the same volume, p. 382, Dr Garthshore relates an instance of semi-retroversion.

NOTE 4. p. 172. In the case described by Dr Hunter, *Med. Obs. and Inq.* Vol. IV. p. 400. the bladder after death was found to be amazingly distended, but not ruptured.

NOTE 5. p. 173. In Mr Lynn's case, the bladder burst, and immediately afterwards the woman miscarried, but the uterus after death was found to be still displaced. *Med. Obs. and Inq.* Vol. V. p. 388. Dr Squire relates an instance in which the bladder also gave way. *Med. Review for 1801.*

NOTE 6. p. 173. In Mr Wilmer's case, the belly was greatly distended ; six pints of urine were drawn off, but the woman soon died. On inspecting the body, the bladder, from the disease of its surface, was found to contain a quantity of coagulated blood, and the inflammation had spread to the colon. In this case, the umbilicus was protruded like half a melon, and the disease was at one time taken for hernia. The uterus was found to be so firmly wedged in the pelvis, that it could not be raised up till the symphysis pubis was sawed away. *Wilmer's Cases*, p. 284.

NOTE 7. p. 173. In Dr Ross's patient, after the uterus was reduced, abortion took place ; and the woman dying, the bladder was found to be thickened, and adhering to the navel. *Annals of Medicine*, Vol. IV. p. 284.

NOTE 8. p. 173. This is illustrated by Dr Garthshore's patient, who, notwithstanding these symptoms, ultimately did well. After the reduction of the womb she miscarried, and fetid lumps were for some time discharged from the bladder. *Med. Obs. and Inq.* Vol. V. p. 382.

NOTE 9. p. 173. In Mr Croft's case, the disease was of a month's standing, the woman was œdematous, and she was supposed to have dropsy ; but by introducing the catheter, seven quarts of urine were drawn off. The introduction was daily repeated for some time, and then occasionally, as circumstances required, for three weeks. The swelling of the legs went off, and the uterus gradually rose. *Med. Jour.* Vol. XI. p. 381.

NOTE 10. p. 173. A case is related by Mr Ford, in which the catheter, being allowed to slip into the bladder, produced a sinous ulcer. *Med. Facts*, Vol. I. p. 96.

NOTE 11. p. 173. In Mr Hooper's case, whenever the tumor was pressed back, the woman called out that she could now make water. *Med. Obs. and Inq.* Vol. V. p. 104.

NOTE 12. p. 173. This was done by Dr Cheston. The woman remained long very ill, but she carried her child to the full time, and recovered. *Med. Commun.* Vol. II. p. 96. In one instance, by using a long trocar, the uterus was wounded, and the woman died.

NOTE 13. p. 174. Dr Hunter mentions a case, in which the uterus rose covered itself immediately after the bladder was emptied. *Med. Obs.* Vol. IV. p. 408. And in Mr Croft's second case, the water having been drawn off for six days, the uterus suddenly rose. *Lond. Med. Jour.* Vol. XI. p. 384.

NOTE 14. p. 175. Both Dr Ross's patient, and Dr Cheston's patient, the latter of whom recovered, complained of uneasiness in the throat, which Dr C. considers as a mark of slow peritoneal inflammation.

NOTE 15. p. 175. This circumstance has been mentioned by different writers, and a distinct case is related by Mr Merriman, in the *Med. and Phys. Jour.* Vol. XVI. p. 388. Mrs F. being about five months pregnant, was suddenly terrified, and felt as if her inside were turned upside down. The symptoms, however, were not very acute, for she voided the urine in the last month of gestation, though with pain and some difficulty. On the 16th of June, she had some pains, and a discharge of serous fluid; no os uteri could be felt, but a large semi-globular tumor at the back part of the vagina, bearing down toward the perinæum. The pains brought on fever, and at last delirium and convulsions. She was bled, and had a clyster, after which she got some sleep; and the pains continued moderate, though regular, for two or three days, and she passed both urine and stools. On the 20th, nothing like os uteri could be felt; but on the 21st, there was perceived a thick flattened fleshy substance descending into the vagina, and very soon the uterus was restored to its natural situation. The substance was found to be the scalp of the child, containing loose bones. The child and placenta were delivered, and the mother recovered.

NOTE 16. p. 176. In Mr Bird's case, the accident succeeded to stooping, in washing clothes. *Med. Obs. and Inq.* Vol. V. p. 110. In Mr Hooper's case, the woman was frightened by an ox, and in attempting to escape, fell down, after which the symptoms appeared. Mr Evan's patient ascribed it to lifting a burden. *Med. Comment.* Vol. VI. p. 215; and Mr Swan's patient to a fall; p. 217. Mr Merriman's patient first complained after being suddenly terrified; and Mr Wilmer's patient had the uterus retroverted, after being fatigued with weeding.

NOTE 17. p. 176. Vide Chambon. *Malad. de la Grossesse*, p. 16. M. Baudelocque relates a case from the practice of Choppart, where it was produced in the second month of pregnancy, by the action of an emetic. *L'Art; &c.* § 255.

NOTE 18. p. 177. Sometimes the hemorrhage proves fatal. A singular case is to be met with in the *Medical facts*, Vol. III. p. 171, by Canestrini, where the woman had a double uterus. One of the uteri, after some pains, burst in the fourth month. The ovum was found entire in the abdomen, and much blood was effused.

NOTE 19. p. 177. A twin case is related by Dr J. Hamilton, where the uterus was so thin, that even the sutures of the head could be felt through the abdominal parietes. Violent pains were produced by the motion of the child, the uterus felt very light, and the woman had been exposed to a degree of violence. This case had a very considerable resemblance, in some respects, to a ruptured uterus, but she was delivered safely of two children. *Cases*, p. 124.



NOTE 30. p. 177. Sometimes the tumor rather increases. In Dr Percival's case, the belly became much larger after the accident, and continued so for about a year. Then it subsided all at once, when the woman was in a recumbent posture. *Med. Comment. Vol. II. p. 77.*

NOTE 21. p. 177. Dr Drake's case, where the uterus seemed to burst in the fourth month, terminated by suppuration at the navel. Excrement was for some time discharged at the opening. *Phil. Trans. Vol. XLV. p. 121.*—A washerwoman at Brest had the uterus ruptured by a fall in the seventh month, and ultimately expelled the fœtus at the navel. *Mem. of Acad. of Sciences for 1709.*—Guillerm, in the same work for 1746, mentions a woman who had the womb ruptured by a fall in the sixth month. She immediately fainted, and a discharge took place from the vagina. The child was expelled by the anus.—See also the cases by Dr Percival, Mr Wilson, &c.

NOTE 22. p. 177. In the *Journ. de Med. for 1780*, there is a case of a woman, who had the uterus ruptured in the fourth month of pregnancy. The accident was followed by uterine hemorrhage, which continued for some time. The menses returned, but the belly did not subside. In the ninth month she died. The uterus was found of the natural size, but the rent was still perceptible.

NOTE 23. p. 177. In the *Journal de Med. for 1780*, a case is detailed of a woman, who, in the month of January, being then seven months pregnant, was squeezed betwixt the wall and a carriage, and had the uterus ruptured. She instantly felt violent pain in the belly, and a discharge took place from the vagina, which continued in variable quantity for six weeks. The strength gradually sunk, and in June she began to vomit, and continued to do so for several days, when she died. The abdomen was found inflamed, and contained the remains of a putrid child. The rent was visible in the womb.

NOTE 24. p. 178. In Mr Wilson's patient, the accident was produced by being kicked. She complained of pains all night after the injury, and next day had a sanguineous discharge from the vagina, and soon afterwards was attacked with violent griping pain. The fœtus was ultimately discharged by an abscess, bursting externally. *Annals of Med. Vol. II. p. 317, and Vol. IV. p. 401.*—Dr Garthshore's patient ascribed it to violent exercise. *Med. Journal, Vol. VIII. p. 334.*—Mr Goodsir's patient to exertion. *Annals of Med. Vol. VII. p. 412.*—In the 5th and 6th volume of the *Journal de Med.* are two cases, the first produced by a fall from a tree, the second by a bruise from a waggon. Other instances, if necessary, might be added.

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## BOOK. II.

### CHAP. II.

NOTE 1. p. 268. "The Greenlanders, mostly, do all their common business just before and after their delivery; and a still-born or deformed child is seldom heard of." *Crantz's History of Greenland, Vol. I. p. 161.*

Long tells us, that the American Indians, as soon as they bear a child go into the water and immerse it. One evening he asked an Indian where his wife was; "he supposed she had gone into the woods, to set a collar for a partridge." In about an hour she returned with a new born infant in her arms, and coming up to me, said, in Chippoway, "Oway saggonash payshik shoma-gonish;" or, "Here, Englishman, is a young warrior." *Travels*, p. 59.

"Comme les accouchemens sont tres-aises en Perse, de meme que dans les autres pais chauds de l'Orient, il n'y a point de sages femmes. Les parentes agees et les plus graves, font cet office, mais comme il n'y a gueres de vieilles matrones dans le harm, on en fait venir dehors dans le besoin." *Voyages de M. Chardin*, Tom. VI. p. 230.

Lempriere says, "Women in this country, (Morocco,) suffer but little inconvenience from child bearing. They are frequently up next day, and go through all the duties of the house with the infant on their back." *Tour*, p. 328.

Winterbottom says, that, "with the Africans, the labour is very easy, and trusted solely to Nature, nobody knowing of it till the woman appears at the door of the hut with the child. "Account of Native Africans," &c. Vol. II. p. 209.

The Shangalla women "bring forth children with the utmost ease, and never rest or confine themselves after delivery; but washing themselves and the child with cold water, they wrap it up in a soft cloth, made of the bark of trees, and hang it up on a branch, that the large ants with which they are infested, and the serpents, may not devour it." *Bruce's Travels*, Vol. II. p. 553.

In Otaheita, New South Wales, Surinam, &c. parturition is very easy, and many more instances might, if necessary, be adduced. We are not however to suppose, that in warm climates women do not sometimes suffer materially. In the East Indies, "many of the women lose their lives the first time they bring forth." *Bartolomeo's Voyage*, chap. 11.

Undomesticated animals generally bring forth their young with considerable ease, but sometimes they suffer much pain, and, when domesticated, occasionally lose their lives.

## CHAP. II.

NOTE 1. p. 289. Dr Smellie relates two cases of this kind. In the first he brought away the indurated portion, but the woman died from hemorrhage. In the second he left the adhering portion, and the woman recovered. *Coll.* 23. c. 1, and 2. See also Giffard's cases, c. 119 and 127; and La Motte, c. 358 and 362. In these, although the adhesion was very intimate, he brought away the placenta in pieces.

## CHAP. VI.

NOTE 1. p. 334. Although it was the opinion of those who first described the forceps, that it was the instrument used by Chamberlain; yet of late some have supposed, but without very positive proof, that he employed the lever-

This last instrument was about the same time used as a secret practice, by Rhoonhuysen, but was not divulged until about the middle of the last century. It was so constructed, as to be a very unsafe instrument, especially in rash hands. Mr Giffard, in the beginning of the century, had repeatedly used one of the blades of his extractor or forceps, to draw or pull down the head; and much about the same time, Mr Chapman, in one instance, performed a similar delivery. Vide Treatise, p. 186. It has been said, that Chamberlain sold the secret of the forceps to Rhoonhuysen, who, finding that he could deliver with one of the blades, improved on it, and converted it into a lever; but the dissimilarity of the two instruments at that time, is an objection to that opinion. Plates of the different forceps and levers at present in use may be seen in Savigny's engravings; and a very concise account of all the different improvements and alterations of these instruments from their discovery to the present time, may be found in Mulder's *Hist. Liter. et Critica Forcepium et Vectium Obstetricorum*. I do not think it necessary to describe the forceps, nor do I consider the slight variations made by different practitioners as of great importance. I prefer those, however, proposed by Dr Lowder and Dr Pole, to others. A particular kind of forceps, with three blades, was employed by Dr Leak, but it is never used.

NOTE 2. p. 342. The signs of a dead child have been described to be a feeling of weight, or sensation of rolling in the uterus, want of motion of the child, pallid countenance and sunk eye, coldness of the abdomen, with diminution of size, flaccid breasts which contain no milk, fætor of the discharge from the vagina, liquor amnii coloured apparently with meconium, although the head presents, puffy feeling of the head, want of firm tumor formed by the scalp when the head is pressed in a narrow pelvis, no pulsation in the cord, &c. Most of the cases requiring the crotchet cannot be benefited by any marks characterising death of the child in the progress of gestation; and we well know, that the child may die during labour, without testifying this for a length of time by any sensible signs; and that those enumerated above are deceitful, I believe every attentive and unprejudiced practitioner will join with me in maintaining. Nothing but unequivocal marks of putrefaction of the child itself can make us certain, and these cannot be discovered for some time. Fætor of the discharge is not a test of this. Vide Mauriceau, obs. 281. When a woman bears a child which has been for some time dead, we must watch lest her recovery prove bad.

NOTE 3. p. 346. This practice was first adopted about the middle of the last century, by Dr Macauley in London, and was afterwards followed out by others. About twenty years after this, it was proposed on the continent by M. Roussel de Vauzeme; and lately Mr Barlow, in the eighth Vol. of *Med. Facts*, &c. has given several cases of its success.—See also *Med. and Phys. Journal*, Vols. XIX. XX. and XXI. It may not be improper for me to mention as a caution, that I have been called to consider the expediency of evacuating the liquor amnii, where there was no deformity of the pelvis, but merely a collection of indurated fæces in the rectum.



## CHAP. VII.

NOTE 1. p. 350. I believe few will dispute, that the precise deformity requiring the cæsarean operation, must, to a certain extent, be modified by the dexterity of the operator. I shall suppose, that a surgeon, in a remote part of the country, far from assistance, is called to a patient whose child is evidently alive, and whose pelvis measures just as much as would render it barely possible to use the crotchet, were he dexterous; but he has not a belief that he could accomplish the delivery with that instrument. Would that man be wrong in performing the cæsarean operation? In such a case I would say, upon the principle that a man is to do the most good in his power, that if no operator more experienced can be had, within such time as can be safely granted, the surgeon ought, after taking the best advice he can procure, to perform the cæsarean operation, by which he will save one life at least. By the opposite conduct, there is ground to fear that both would be lost. In a case related in the *Jour. de Med.* for 1780, a woman in the village of Son had the child turned, and even the limbs separated, without delivery being accomplished; four days afterwards, the cæsarean operation was performed, and the woman died.

## CHAP. VIII.

NOTE 1. p. 359. Dr Bland is rather against delivery, and for trusting to nature. Dr Garthshore, *Jour.* VIII. 359, says, more women have recovered of this, who were not delivered, than of those who were violently delivered.—Dr Denman concludes, that women, in the beginning of labour, ought not to be delivered, II. 381, and admits of it only when it can be done easily.—Baudeloque, says, that we ought not to be in haste to deliver, and never to do it when nature seems to be disposed to do it herself. Dr Hull, *Obs. &c.* p. 245, says, that we should trust to the usual remedies, till the os uteri be easily dilatable, or be dilated, and then deliver. He informs me, that in every case which proved fatal, there was no dilatation of the os uteri.

NOTE 2. p. 359. Dr Osborn, p. 50, says, that no remedy can be used with any reasonable expectation of benefit, till delivery is completed; and that therefore it is our indispensable duty to affect it in the quickest possible manner.—Dr J. Hamilton, *Annals*, V. 318, et seqr. says, that when convulsions occur during labour, delivery is to be accomplished as soon as possible.—Dr Leak. that when they seem to proceed from the uterus, speedy delivery is useful; but when from “any cause independent of the state of pregnancy,” delivery would be hurtful, II. 348.

NOTE 3, p. 360. In a case which I saw, the placenta was retained by a spasmodic stricture, though the child was expelled; every allowable attempt was made to extract it, but in vain. The uterus acted from the os uteri towards the rent, which was at the fundus. The woman died. The placenta was found still in utero. The intestines were inflamed. See also Crantz, de *Utero Rupto*, p. 22; and Dr Cathral's case in *Med. Facts*, vol. VIII. p. 146.

NOTE 4. p. 364. Vide successful case by Thibault, in *Jour. de Med.* for May 1768.—M. Baudelocque relates a case where the operation was twice performed on the same patient, for the same cause. In *Essays Phys. and Lit.* Vol. II. p. 370, is a case most incredible, where both the uterus and abdominal integuments were torn during labour. The child escaped, and the woman recovered.

NOTE 5. p. 364. Astruc. liv. v. chap. iv. quotes a case, where the child remained in the abdomen for 25 years. In another case, the midwife felt the child's head, but after a severe pain it disappeared, and the woman complained only of weight in the belly. It was expelled by abscess. *Hist. de la Societé de Med.* Tom. I. p. 388. In Dr Bayle's case, the child was retained twenty years. *Phil. Trans.* No. 139, p. 997. In Mr Birbeck's case, the child was discharged by the navel. *Phil. Trans.* vol. XXII. p. 1000. Bromfield's patient did not get rid of the child, but she lived for many years, and after death the rent was visible. *Phil. Trans.* vol. XLI. p. 696. In Dr Sym's patient, the process for expelling the child by abscess was in a favourable train, when, by imprudent exertion, fatal inflammation was excited. *Med. Facts*, vol. VIII. p. 150. Bartholin also gives cases. Le Dran relates an instance, where the uterus was ruptured on the 23d of April. On the 13th of May the placenta was expelled; on the 16th a tumor appeared at the linea alba, which was opened, and a child extracted; the woman recovered. *Obs.* Tom. II. ob. 92.

NOTE 6. p. 364. In a case communicated to Dr Hunter, the forceps were pushed through the cervix uteri, and the intervening portion between the laceration, and the os uteri was afterwards cut. The labour was finished naturally, and the woman recovered. *Med. Jour.* vol. VIII. p. 368. Dr Douglass relates the successful case of Mrs Manning, in his *Observations*, p. 7. Dr A. Hamilton gives a fortunate case, where delivery saved the mother. *Outlines*, p. 384; and Dr J. Hamilton, relates one in his *Cases*, p. 133, where the rent had contracted so much, as to give some difficulty to the delivery. The case is instructive.

M. Coffiners gives a memoir on this subject, in the *Recueil Period.* Tom. VI. in which he remarks, that laceration near the vulva is easily cured; at the upper lateral part of the vagina, it is dangerous; and at the anterior and posterior part, near the bladder and rectum, it is generally mortal; but in one case the woman recovered, although the hand could be introduced into the bladder. The woman had incontinence of urine afterwards. In his eighth case, the child lay transversely, and the vagina was torn, and filled with clots; but the peritoneum was still entire, and therefore the wound did not enter the abdomen. The uterus was supported with a napkin until the child was turned. Dangerous symptoms supervened, but the woman recovered. He gives fifteen cases, and of these, six recovered. Several were produced by attempts to reduce the arm of the child.

## BOOK III.

## CHAP. I.

Page 366. If sloughing of the neck of the bladder should take place, and a small opening be formed, a catheter must be kept in the urethra and bladder, and the wound dressed with a pledgit dipped in lime water, mixed with tincture of myrrh; then a soft compress is to be cautiously introduced into the vagina, to support the parts. Great attention is to be paid to cleanliness.

## CHAP. III.

NOTE I. p. 381. Mr White of Paisley describes it very well, as resembling a printer's ball. *Med. Com.* vol. XX. p. 147. Sometimes it does not pass through the os uteri. *Denman*, II. p. 351.

*Mangetus*, lib. IV. p. 1019, relates a fatal case, where the tumor was taken for the head of a second child. It was at first partiality, and then completely, inverted with excruciating pain.

Mr Smith relates a case of inversion, where the accident was followed by syncope, subsultus, &c. The subsultus and frequent pulse continued for some days, with smart fever, and inability to move. *Med. and Phys. Jour.* vol. VI. p. 503. In the same volume, Mr Primrose gives an instance where a great part of the uterus sloughed off, and the woman recovered.

NOTE 2. p. 382. *La Motte*, 383, mentions a woman who had inversion for above thirty years. *Dr Cleghorn*, *Med. Commun.* II. 226, relates a case, where the uterus slowly returned to its natural size. This woman still menstruates, and enjoys tolerable health; it has been of twenty years standing. The womb is smooth, moist, and gives little pain. Menstruation also continued in *Dr Hamilton's* case, *Com.* XVI. p. 315.

NOTE 3. p. 384. The inverted uterus has been torn off with the erotchet, being mistaken for the child's head. *Jour. de Med.* Tom XLI. p. 40. A case of successful extirpation is inserted in the same work for August 1786. *Wrisberg* relates a case, where it was cut off by the midwife, who had inverted it. A successful case is given by *Dr Clarke*, in *Edin. Med. and Surg. Jour.* vol. II. p. 419. Another case is mentioned in the *Recueil des Actes de la Societ  de Lyon*. Mr Hunter of *Dumbarton* gives a successful case, in *Annals of Med.* vol. IV. 366. I have particularly examined this woman, several years after the operation. She was delivered without any violence, after having been twenty-four hours in labour. In about an hour the placenta came away. She had considerable flooding and great weakness. She could not void her urine, which in two days was drawn off with the catheter, and this was frequently repeated. A fortnight after delivery, the womb came down, with pains. It



was replaced, but again came down. A fœtid discharge took place, and the woman was reduced to a state of great weakness. A ligature was applied, which, she says, gave her a good deal of pain, and the tumour was cut off. Her account differs in some respects from Mr Hunter's, probably owing to her speaking from memory alone, some years after the event; and she does not notice the previous extraction of any lumps from the uterus, which Mr Hunter mentions, for most likely she did know of that. About two years ago, she had for a length of time a discharge of thick white matter. At present, the vagina is of the usual length; and at the top, a transverse aperture is felt, the posterior lip or edge of which is longer and more tendinous to the feel, than the anterior. It admits the tip of the finger, and feels softer than the os uteri, in a natural state. There is no cervix uteri. The mammæ are firm, and of good size, and she has not lost the sexual desire. She is subject to dyspepsia. From the preparation in the possession of Dr Jeffray, there can be little doubt that part of the uterus was extirpated.

Bartholin relates a case, where the inverted womb was torn away, and found under the bed of the dead patient.—Blasius, a case, where the uterus was hard and scirrhus; it was tied, but on the third day the patient died. In the cavity of the portion were found the ovaria and ligaments.—Goulard's patient died on the 18th day. *Mem. of Acad. de Sciences*, 1732.

## CHAP. VII.

Page 391.—When a patient is known to be subject to syncope or spasmodic disease after delivery, a dose of *spt. ammon. arom.* combined with tincture of opium, should be ready for her after the child is expelled, and the abdomen ought to be duly supported.

## CHAP. VIII.

NOTE 1. p. 410.—Dr Denman, Vol. II. p. 493, considers puerperal fever as contagious. He strongly advises early bleeding, giving an emetic or antimonial, so as to vomit, purge, or cause perspiration; and if this does good, he repeats the dose, and uses clysters, fomentations, leeches, and blisters. He gives an opiate at night, and a laxative in the morning; or, if there be great diarrhœa, he employs emollient clysters. The strength is to be supported by *spt. ether nit.* or other cordials.

Dr Leak, Vol. II. trusts much to blood-letting; if the patient be sick, he gives a gentle vomit; if not, laxatives, and then antimonials; applies blisters, and in the end restrains purging with opiates, and prescribes bark.

Dr Gordon, p. 77, et seq. depends on early and copious blood-letting, taking at first from 20 to 24 ounces, and purges with calomel and jalap. He is regulated rather by the period of the disease than the state of the pulse, bleeding, though it be feeble.

Dr Butter purges and bleeds only where there is well marked inflammation, and is satisfied often with taking only three ounces of blood at a time, when there is an exacerbation.

Dr Manning very rarely bleeds, but trusts to emetics and purges, and employs Dr Denman's antimonial, which is two grains of tartar emetic, mixed with oil of crab's eyes, and the dose is from three to ten grains.

Dr. Walsh forbids venesection, and advises emetics, followed by opiates and cordials.

Dr Hulm trusts to clysters, purges, and diaphoretics, and does not bleed unless there be pain in the hypogastrium, accompanied with violent stitches, and a resisting pulse. Even then he bleeds sparingly.

M. Douleat advises repeated emetics, followed by oily potions, and bark, combined with camphor.

Mr Whyte is against blood-letting. He gives at first a gentle emetic, followed by a laxative and diaphoretics. Then he gives bark, with vitriolic acid, and supports the strength.

Dr Joseph Clark trusts chiefly to saline purges and fomentations.

Dr John Clarke, in his excellent Essays, forbids venesection, and advises bark as freely as the stomach will bear it. Opium is also to be given, together with a moderate quantity of wine, along with sago. If there be much purging, the bark is to be omitted, till some rhubarb be given, or a vomit, if there be little pain in the belly.

Dr Kirkland bleeds only if the patient have had little uterine discharge, and the pulse indicate it. He employs laxatives, and in the end bark and camphor.

Dr Hull considers this disease as simple peritoneal inflammation, which may affect three classes, the robust, the feeble, and those who are in an intermediate state. In the first he bleeds and purges, in the second he begins with emetics and ends with bark, and in the third he bleeds with great caution.

Dr Hamilton advises puerperal to be treated as putrid fever.

Guinot, Allan, and others, recommend carbonate of potash, in doses of ten or fifteen grains.

M. Vigarous joins with those who consider this as not a fever *sui generis*, but one varying according to circumstances. It frequently begins, he says, before delivery, but becomes formed about the third day after it. He has five different species. 1st, The gastrobilious, proceeding from accumulation of bile during pregnancy. The essential symptom of this species is intense pain in the hypogastrium. He advises first ipecacuanha, which he trusts to chiefly, and then clysters, laxatives, and saline julap. 2d, The putrid bilious. This is occasioned by bleeding, or neglecting evacuations in the former species; or even without improper treatment, the fever may from the first be so violent, that bilious matter is absorbed. It is marked by great debility, small or intermitting pulse, tumor of the hypogastrium, with sharp pain and putrid symptoms, aphthæ, vomiting, fetid stools, &c. He advises vomits, laxatives, and bark in great doses, with mineral acids, and clysters containing camphor. 3d, The pituitous fever, attended with vomiting of pituita. The

surface is pale, the pulse has not the force or frequency it has on the former species, the heat in general not increased, anxiety, weight, and vertigo, rather than pain of head, often miliary spots, and the usual symptoms of pain in the belly, and subsidence of the breasts. He gives vomits, and afterwards three or four grains of ipeacuanha every three hours. If he uses purgatives, he conjoins them with tonics. 4th, With phlogistic affection, or inflammation of the womb, attended with great weight about the pelvis, swelling pain, and hardness in the lower belly, suppression of evacuations, sharp frequent pulse, acute fever, and the countenance not so sunk as in the putrid disease. He advises venesection, leeches, and low diet. The same remedies, with blisters, are to be used, if pleuritic symptoms occur. 5th, Sporadic fever, proceeding from cold, passions of the mind, &c. Puerperal fever he considers as apt to terminate in milky deposits in the brain, chest, legs, &c.

When upon this subject, it may not be improper to mention, that a young practitioner may mistake spasmodic affections, or choleric pains, for puerperal inflammation; for in such cases there is often retching and sensibility of the muscles, which renders pressure painful. But there is less heat of the skin, the tongue is moist, the pulse, though it may be frequent, is soft, the feet are often cold, the pain has great remissions if it do not go off completely, there is little fulness of the belly, and the patient is troubled with flatulence. It requires laxatives, antispasmodics, anodyne clysters, and friction with camphorated spirits. Blood drawn in this disease, after it has continued for some hours, even when the woman is not in childbed, is sizy, and it is always so in the puerperal, as well as the pregnant state, although the woman be well.

## CHAP. XIV.

NOTE, p. 412. In some instances, the patient has been sensible of the pain, which expelled the child, rushing violently down the leg. After a short time it has abated, but about the usual period this disease has appeared. After the pain and swelling have gone off, the muscles are in some cases left paralytic, and the joints loose and weak.

## CHAP. XXI.

Page 425. Some women feel, after lying in, a considerable weakness or sensation of want about the belly, which is frequently increased by nursing. It is often produced by taking off the bandage too soon from the abdomen, which should not be done for a month at least, and is relieved by the application of a broad firm band round the belly. This is also useful, especially when made to act upon the hips, in that kind of uneasiness and dragging, which is felt about the haunches and sacrum, or loins, when the uterus threatens to prolapse in consequence of walking too soon after delivery. These sensations, together with the disease, will continue long, and increase, if attention be not paid.



Pain in the side, or in the abdomen, which is sometimes produced by nursing, is often relieved by friction, warm plasters, and an invigorating plan. General weakness require tonics, which must be varied.

## BOOK V.

### CHAP. I.

§ 2. p. 432. The white substance, found on the skin of new-born children, feels unctuous like butter, but it does not melt by heat. When held in the fire on a spatula, it soon resembles curd, and then crackles or detonates, and flies off in small portions. It dissolves readily in spirit of wine, or oil of turpentine, or fixed oils, and hence butter is sometimes used for removing it; but it is also rendered miscible with water by means of soap.

NOTE 1. p. 434. In choosing a nurse, it is necessary to be satisfied that she enjoys good health, and has an adequate supply of milk. Certain rules have been laid down to enable us to ascertain the quality of the milk by its appearance; but it is sufficient that it be not too thick, and have a good taste. With regard to the quantity, we cannot judge at first, for the milk may be kept up so as to distend the breast, and give it a full appearance. A woman who is above the age of 35 years, or who has small flaccid breasts or excoriated nipples, or who menstruates during lactation, or who is of a passionate disposition, should not be employed as a nurse. Those who labour under hereditary diseases should, at least for prudential motives, be rejected. The woman's child, if alive, should be inspected, to ascertain how it has thriven, and both it and the nipple should be examined, lest the nurse may have syphilis. A woman who has already nursed several months is not to be chosen, as the milk is apt to go away in some time, or become bad. It is farther of great advantage to attend to the moral conduct of the nurse, for those who get drunk, or are dissipated, may do the child much mischief.

With regard to the diet of a nurse, it is improper to pamper her, or make much difference in the quality of the food, from what she has been accustomed to. It is also proper that she be employed in some little duty in the family, otherwise she becomes indolent and overgrown.

### CHAP. IV.

§ 7. p. 457. The *ignis sylvestris* is sometimes accompanied with considerable inflammation round the small pustules on the face, which are intermixed with herpetic spots and vesicles. This affection is very itchy. It is cured by bathing the parts frequently with lemon juice, or applying an ointment containing camphor and sulphur. An eruption of papulæ like prurigo, or of small vesicles with inflamed margins, sometimes appears at the same time on the arms, and requires similar applications.

§ 17. p. 470. The pityriasis seems sometimes to be infectious. A variety

of it appears like small red marks on the scalp. The circumference extends, and continues red, whilst the centre becomes pale and scaly. It is accompanied with falling off of the hair.

NOTE 1. p. 486. M. Mahon, from his observations in l'Hospit e de Vaugirard, says, that the symptoms appear as follows, the most frequent being put first. Ophthalmy; purulent spots; ulcerations: tumors; chaneres on the mouth, and aphthæ; livid, ulcerating, and scabbing pustules: chaneres on the genitals, and about the anus; excrescences; peeling off of the nails of the feet and hands.

NOTE 2. p. 487. Children may have ulceration about the anus, genitals, and groins, succeeding intertrigo, owing to neglect of cleanliness, without any venereal affection. But the absence of other symptoms, particularly of sore throat, or ulcer of the mouth, and the amendment experienced by the use of lotions, and keeping the part dry and clean, will enable the practitioner to form a diagnosis, and the aspect of the sores will assist him. This fretting of the parts, and even some degree of excrescence may attend psoriasis, and the herpetic spots of children formerly described; and in this case, especially if the child belong to a poor person, the disease is too often decided to be syphilis. There is, however, perhaps no individual symptom, which can decidedly characterize syphilis in children; and the diagnosis must be formed by the combination of symptoms, and often by the progress of the disease. Many children are rashly put upon a course of mercury, who do not require it; perhaps, because the practitioner thinks it a point of honour, to determine the nature of the disease at the first glance.

NOTE 3. p. 491. Adults are sometimes seized with this disease. A very remarkable case of this kind is recorded in the 48th vol. of the Phil. Trans.—The subject of it was a girl, aged 17 years. She had excessive tension, and hardness of the skin, all over the body, so that she could hardly move. The skin felt like a dry hide or piece of wood, but she had some sensation when pressed on with the nail or a pin. It was cold and dry, the pulse was deep and obscure, but the digestion good. It began in the neck, then affected the face and forehead, and at last she could scarcely open the mouth.

NOTE 5. p. 496. If the progress have been very favourable, the arm, about the eighth or tenth day, will exhibit a circular elevation, flattened on the surface, and surrounded with circumscribed redness. With this state of the arm, unattended with high fever, we may be sure that the patient will do well and probably the secondary pustules will not mature. If the elevation of the cuticle be less marked, perhaps not circular, but at the same time not with jagged edges, if the surrounding redness follow the irregular shape of the pustule at a considerable distance, having, however, its circumference defined and not shaded, then, though the fever may have been higher than in the former case, yet we may be sure that the danger is over; and if any pustules appear, they will be late, and probably will not mature. If the inflammation run high at the arm, with surrounding redness, irregular in its figure, and shaded instead of being circumscribed at its circumference, we must examine the arm carefully; if we find a cluster of very small blisters, which are only confluent

from their vielnity, but are distinct at the edges, where they are more distant, we may, although the fever have been considerable, prognosticate that he will have a mild subsequent disease, and that the arm will heal easily. But if this high inflammation be unattended with any distinct little bladders, particularly if, instead of rising above the surface, the inoculated part seems somewhat depressed with a dusky brown skin, as if drawn lightly over it, the fever will be at the same time considerable; and though all constitutional danger may subside with it, yet we may expect a mortified part in the arm, but it will be cured by exposing it to the air. Popular View, p. 63, et seqr.

## CHAP. V.

NOTE, p. 420. There is an affection, which is liable to be confounded with chronic hydrocephalus. The patient complains of his head and neck for a length of time, as the pain is increased by exercise, agitation, or reading long, and sometimes he squints. The pain, however, is rheumatic, follows the course of that disease, is not constant, and shifts its place. The squinting is either habitual, and consequently accidental with regard to the disease, or it is caused by a temporary affection of the muscles of the eye, and is increased by looking long at any object. The patient is easily agitated, and, at a more advanced age, would be said to be hysterical. Laxatives, bark, and sea bathing, are useful.

THE END.

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